Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2011 Physician/ Month April 16. 9:00 P M Eugene Thomas Quinn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Care Baltimore Towson 5. Social Security Number If Under 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days Hours (Month, Day Year) Months 219-16-8196 Yrs Oct. 1923 Maryland **Director** 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 719 Maiden Choice Lane, Apt. BR405 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 43'-45' 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Sales Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anne Elizabeth Herr Thomas Quinn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. Quinn/Son 1540 West Ridge St., Apt. 15 Marquette, MI 49855 20a. Method of Disposition 20b. Place of Disposition (Name of May 4, 20c. Location - City or Town, State Garrison Forest Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Owings Mills, MD 22. Name and Address of Facility Home of Dulaney Valley J. Flag1e 10 W. Padonia Road Michael Timonium, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Month Day Year signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 🗌 No 1 \square Yes Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 1 Yes 2 100 ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Harrice funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Director: filled in by the 2 Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Division of Vital Records, P.O. Box 68760 e Funeral completed To the I within 2. To the F

> h State Registrar

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of certifie

KUMAR

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's S

only one 29b. Signature and title

ARATHI

31. Date filed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month, Day, Year,

MD21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APCI John J. Ruszala, Jr. Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WSON If Under 24 Hrs. If Under 1 Year 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Min 215-30-8428 Maryland 77 March 30,1934 Director Usual Residence of Decedent a or 28a-f show be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Baltimore 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 21234 2414 Perring Woods Road USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, à 1 Never Married 2 Married X Yes 2 No Yes, Give Maryland 21215-0036 Specify: white 1 Yes 2 No Specify: Completed 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Department Manager the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic ever Mental Catherine Ochal John Ruszala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2414 Perring Woods Road-Baltimore, Maryland 21234 Frances Kahler-caregiver Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dulaney Valley Memorial Gardens 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 20,2011 Timonium, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. mmediate Cause (Final Onset and Death Physician/ se e or condition e ting in death) Kespiratory Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificete be executed Cause (Disease or iinjury that initiated events resulting in death) Last Schemic burial-tran and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Failure Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should Obstructive Pulmonary Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 No Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours To the Funeral C the Hospital Medical 29a. Certifier Descritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature um State Registrar

DHMH 17 Rev 7/2009

11-02847 Renee Rebbert Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		tificate of Death		Reg.	No.	
Physician Medical Examine	1. Oecedent's Name (First, Middle,L				2. Date of Death	ay Year	3. Time of Death 1445 hrs
	4a. Facility Name (if not institution, GBMC		Tows	own, or Location of De	ath	4c. County of Oeath Baltimore Cou	nty
Funeral Director	215-68-4443	Sex 7. Age (In yrs. last	Yrs. If Unde Months		8. Oate of Birth(971 9. Birt	
·land -f shaw any once.	Usual Residence of Decedent 10a. State 10b. County MD Harfor		Town or Location				10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f shr autified at once	10e. Street and Number 30l West Ridin	g Drive	10f. Zip	21014	10g.	Citizen of What Cour USA	try?
fter death wii	11. Marital Status 1 X Never Married 2 Marri 3 Widowed 4 Oivord	1 Yes 2 X No ed If Yes, Give Year	13. Was Oeceder If Yes, specify	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black, White
ä ∄ ∄ †	15. Decedent's Education (Specify Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, La	or Dates:	16a. Oecedent's Usual C			6b. Kind of Business/li	ndustry
ID 21215-0036 2 should be filed within 72 he and Mental Hygiene. 77 is marked meter than "as, matte event, the Medical E. T. To Be Commeleded		•		18.Mother's Na	me (First, Middle, Mai Schmidt	den Surname)	
MD 21 d 2 should th and Mee n 27 is man numatic ev	o 19a. Informant's Name/Relationship Dr. Richard Rel	bert (father)		Riding Dri		r, City or Town, State, ir, MD 210	
Baltimore, MC sernit. Pages I and 2 s Department of Health as Important: If item 27 njury or other fraum	20a. Method of Disposition 1 X Burial 2 Cremation 3 4 ponation 5 Other Speci	Removal from State co	lace of Disposition (Name rematory or other place) view Mem. G	ardens 04	/18/2011	Fallston,	Maryland
	21. Signature of Funeral Service Lib		610 W.	MacPhail R	d., Bel Ai	ineral Home ir, MD 210	e, Bel Air 14
Physician /Medical kaminer	23a. Part I. Enter the disease, or cor failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	each line. a. <u>Complications</u>	of Cerebral		c or respiratory arrest,	, shock, or heart	Approximate Interval Between Onset and Death
	Sequentially list conditions,	Due to (or as a consequence of): Oue to (or es a consequence of):					
asi ed	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):	:				11
execut ()(d AMENDED 23a,27,p	per me,g916	6-24-11 sm	1		
		23c. If yes, outcome of pregna 1 Live birth 4 Pregnant at time of deat	2 Fetal death	3 Ectopic preg	inancy	23d. Date of delivery Month D	ay Year
res that the de signed by the detached for the phy	a	contributing to death but not res	sulting in the underlying o	ause given in Part I.		cco use contribute to t	
Division of Vital Records, P.O. Box 68: To the Hopital or Attending Physician: The law requires that the death certify within 24 hours after death. Where Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as tendinal Certification: To Re Commissed by Diversional					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of S 2 No
ician: ician: certif rector,	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 E		Place of Death (Chec			
on of Vi nding Physi th. T: After this te funeral dir	. Z/. Maillel of Death	28a. Date of Injury (Month, Day, Year)	ER/Outpatient 3 DO 28b. Time of Injury 28	C. Injury at Work?	28d. Describe how		
Division C Division of Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	2 Accident Investige 3 Suicide 6 Could not 4 Homicide	ot be 28e. Place of Injury - At horr	ne, farm, street, factory, o	ffice building, etc.	28f. Location (Stre or Town, State	et and Number or Run	al Route Number, City
To the Host within 24 hc To the Fun completely !		ician: To the best of my knowledge er:On the basis of examination and and manner stated.					
	29b. Signature and title of certifier	w// MA		D.C.M.E.		9d. Date signed <i>(Mon</i> April 15, 2011	th, Day, Year)
do l	30. Name and address of person who Melissa Brassell, MD	o completed cause of death (Item 2 Assistant Medical Examine	-	et, Baltimore, MI	D 21201		
State Registra	e 31. Date filed (Month DavyYear)	32. Registry's Signalur	we		 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ROBINSON ELIZABETH Month Year **Physician** 11.07 PM 04 201 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE NORTHWEST HOSPI RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months 93 212-01-8068 Director Jan. 23, 1918 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the medical Examinations by notified at Director 1 ☐ Yes 2 No Baltimore Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 U.S.A. 9F 6825 Campfield Rd. Apt. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian. 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes **XX** No Specify 2 Specify: XXWidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) l and 2 should be fil Health and Mental ∺ im 27 Is marked otl Eyler Gregersen traumatic ပ Franzeska Attenberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 Is
any injury or other trau Karen Ropka / Daughter Randallstown, MD 21133 3718 Vega Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View

Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/20/2011 Sykesville, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. chare 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician dan 40(2YOU disease or condition resulting in death) /Medical Due to () s a consequence of) Examiner Sequentially list conditions Examiner if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical Physician; The law requires that the death certificate as attending properties for use as IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. the detached ☐Yes 2 XNo 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy perform certificate **Division of Vital** 2. No 2 No 1 ☐ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwes 5. 1100 31. Date filed (Month, Day, Year) 32. egistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Myrtle Α. Rutter Month 1:02 a M Medical Apri 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Future Care North Point Dundalk Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 - M 25 F Min. 216-20-8448 Director 89 Maryland January Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Md. Baltimore Sparrows Point or 28a-f 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2406 Ketchum Ave. 21219 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married ģ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify. Specify: White Completed 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 years Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Finnerty Charlotte P. Reitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice L. Biggs Daughter 2406 Ketchum Ave. Sparrows Point, Md. 21219 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 18 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Dundalk, Maryland Oak Lawn Cemetery 2011 21. Signature of Funeral /e 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. ra 21222 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death nd hysician/ dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No signed by the atte Month Year 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires Osbohomusis Completed 1 🗆 Yes 2 No 3 Probably 4 thknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy performe certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 100 Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 🗌 Yes Investigation 6 Could not be Accident 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Let Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 69540 04/15/2011. M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21234 204 words 32. Register's Sign State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Clifton 2011 Ross, Jr. Medical 1001 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Himore Washington Medical Ien Burnie HAME If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months (Month, Day, Year) 12/26/1939 Country) 71 Director 213-36-1872 MD Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 202 Hammarlee Road 21060 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. o. 1 \square Never Married 2 $\overline{\mathbf{X}}$ Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 ☐ Yes 2 🔀 No Specify: "natural" 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry Maryland 21215-(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Autobody Repairman <u>Automotive</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First. Middle, Maiden Surname) Clifton Ross, Sr Pauline Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Mrs. Shirley Ross / Wife 202 Hammarlee Road Glen Burnie, MD 21060 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Park 04/19/2011 Elkridge, MD 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD 21. Signature of Funeral Service Licensee Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events subtract in death). Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? 1 Yes 2 9 Unknown 2 □ No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has perform death? 24 hours after death.
Funeral Director. After this certificate is funeral director, pag 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 -ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Could not be 2 Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Within 2 To the F only one) 29b. Signature and title of certific 00005703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUSICAL CONN. GUN GUNNA DIMONU 31. Date filed (Month, Day, Year) APR 19 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 4:32 PM Peter Ravenhill APRIL 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AGNIES HOSPITAL BALTIMORE 5. Social Security Number Sex 1X M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours July 2, 83 Director 212-38-1509 England Usual Residence of Decedent "natural", or items 23a or 28a-f show edital Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The state if item 27 is marked other than "natural", or items 23a or 28a 4 shoury or orlier traumatic event, the Medital Examiner must be notified at ury or orlier traumatic event, the Medital Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 1 ☐ Yes 2 🕅 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 6303 Johnnycake Road 21207 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Engineer Northrop Grumman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Peter Ravenhill Unk. Louisa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Ravenhill, Wife 6303 Johnnycake Road Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or or
once. cemetery, crematory or other place, 1 Burial 2 Caremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/18/11 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ erebro Vascular disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any macing to impose cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Dimito (or as a named negot of attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown typertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural injury 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practionar: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner at other cause (s) (Check 29b. Signature and title of certifier APRIL 16,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVENUE BALTIMORE 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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			ForState	State of Ma	ıryland					Mental Hy	giene				
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9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۾	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates.		If	Yes, specify Cul	oan, Mexica	an, Puerto	Rican, etc.)		14. Race - A Black, V Specify: V	/hite, e	etc.	
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Baltimore $^{\!\prime}_{\!\scriptscriptstyle 0}$ Maryland 21215-0036	. Page 1 a ment of H tant: If ite jury or otl		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speqff)		cen	netery, crem on Pat	sition (Name of atory or other pl rk Ceme t	ery	4/18		Balt	cation - City	, M	D	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Year 01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town or Location of Death 4c. County of Death timor last birthday If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 **Z**M 2 □ F Months Hours Min Director Usual Residence of Decedent items 23a or 28a-f show 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🗹 Yes 2 □ No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify 3 ₩Widowed 4 □ Divorced Specify: Completed B Laci traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 0 19a. Informant's Name/Relationship (Type, Print) (\$13+ec) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Mrs 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State metery, crematory or other place, Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01 21. Signatu Funeral Service Licensee Facility Russ ne and Address Funeral Home, P. A. th 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on just line. Approximate Interval Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Unknown Month Day Year Yes 2 No Unknown signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy certificate 2 🗌 No Yes Vital 25. Was case referred t Certificate: To Be medical 26. Place of Death (Check only one) Hospital: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home eral Director: After this filled in by the funeral di 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 \square Pending iniury Division 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number. deter ined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Morth, Day, Year) State Registrar

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unpend 23a,27,28a-f per me g915 5-4-11 vt

arol Sersen		State of Maryland / Department of Health and Mental F		gible.	
		1- For State Certificate of Death	, 0	teg. No.	12511
Physici	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Dea	ath	3. Time of Death
edical Exam	iner	Carol Ann Sersen	Month April 16, 2		2041 hrs
)		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat Franklin Square Hospital Rosedale	h	4c. County of Dea	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	s I B Date of Bi	rth (MM/DD/YYYY) 9. E	
Director		214-50-5677 1 M 2 F 62 Yrs. Months Days Hours Min	_	For	eign CountryMD
		Usual Residence of Decedent	1 0	0,1310	
v any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
land f shov	Ď	MD Baltimore Middle River			1 Yes 2 No
Mary r 28s	Director	10e. Street and Number 10f. Zip Code 3802 Chestnut Road 21220		10g. Citizen of What Co	ountry?
9, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tent 71 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.		21220		USA	
eath w	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puert		14. Race - Am White, etc	erican Indian, Black,
fter de I", or		1 Yes 2 No 3 Widowed 4 Divorced of Yes, Give Year 1 Yes 2 No specify:		Specify: WI	nite
ours a	d by	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use rel		16b. Kind of Busines	s/Industry
16 n 72 h	olete	Elementary/Secondary (0-12) College (1-4 or 5+)	ired)	own hor	n
OO3	Completed	12(11	/Eiret Middle	Maiden Surname)	ii.e
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Tolan III	en Gaw	,	
21. ould b i Men ic eve	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Nur	TICK nber, City or Town, Sta	te, Zip Code)
MD d 2 sho lith and n 27 is		Robert Sersen /husband 3802 Chestnut Ro	ad Bal		
or free		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	<i>'</i>
Page ment c		4 ponation 5 Other Specify: BayView Crematory 4/	19/11	Baltimo	ore MD
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Menhal Hygiene. Important: If item 71 is marked other than "natural", injury or other traumatic event, the Medical Examiner.				e Ave. Ba	
Physician	-1	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	ral Ho	me of Ess	CEX 21221 Approximate Interval
/Medical		failure. List only one cause on each line. Electrocution complicated by Ath	nerosc1e	rotic	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
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	jine	if any, leading to immediate — Due to (or as a consequence or); cause. Enter Underlying Cause			0
اة ما	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			7.
e executed cian and cial - transit	dical E	d			-
760, ficate be e g physician the burial	ēģ	IF FEMALE: 23c. If yes, outcome of pregnancy			
Box 68760, death certificate be the attending physic of for use as the burner of for use as the	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of delive Month	Day Year
ox 687 eath certific	sicia	Pregnant at time of death 5 Other (Specify)			
by the	Physician/Mec	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did to	obacco use contribute t	o the cause of death?
Records, P.O. The law requires that the fracte has been signed by page 2 should be detack.	Ď	,			obably 4 🗸 Unknown
ords, w requir	Completed		24a, Was		autopsy findings available
e law te has ge 2 sh	Ē			rmed? death?	
tal Rection: The certificate ector, page		25. Was case referred to medical 26.Place of Death (Check	1 ✓ Yes only one)	2 No 1 V	res 2 No
of Vital ng Physician: After this certi	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin	g Home 5	Residence 6 Oth	er:
Ing P	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe I	now injury occurred	
SiOr Attend death cctor:	Satic	2 X Accident Investigation 4-16-11 7:42pm		was elect	
Division spital or Attendit hours after death. ineral Director: A	Certification:	3 Suicide 6 Could not be determined (Specify) Suicide Suicide Could not be determined (Specify) Suicide (Specify)	28f. Location (S or Town, S	Street and Number of Fi state) 3802 Ch	tural Route Number, City estnut Rd.
		29a. Certifier			
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
E 3 E 8	Me	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)
3.8		O.C.M.E.		April 17, 2011	
Others	ı	30. Name and address of person who completed cause of death (Item 23a)			
		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Patient Known as william Silvers

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			State Registrar		Cer	tificate o	of Death		_	Reg. No.		12312
	Physicia		1. Decedent's Name (First, Middle, Last) William Alan Si	lvers					2. Date of Dea	Day	Year 2() i)	3. Time of Death 5: 30 pvv
	Medic Examin		4a. Facility Name (if not institution, give street			4b. City, Tov	n, or Location of	of Death	1.01.1	4c. Coun	ty of Death	
	<u>/</u>		Sinai Haspital of 5. Social Security Number 6. Sex	Baltmore		_	moro,					
	Funeral Director		218-52-2611 1KIN	7. Age (In yrs. la	rst birthday) Yrs.	If Under 1 \ Months D	ear If Under ays Hours	24 Hrs. Min.	8. Date of Birt 1 2 – 1 6 –	1949	9. Birthi Coun Ma 1	place (State or Foreign cryland
	and show	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation					1	10d. Inside City Limits
	Maryl 28a-f ptifiec	Director	MD N/A		Balti	more						1 🎛 Yes 2 ☐ No
	th the		10e. Street and Number		0.05	10f. Zip Co				10g. Citizen o		ntry?
	ath wi	Funeral	6318 Greenspring 11. Marital Status 12.	Ave. Apt. Was Decedent Ever in U.S			1209	in? /Sneo	ify Vac or No	144.5	USA	
တ္တ	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	β	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 □ No	H		of Hispanic Orig Cuban, Mexican	, Puerto R	ican, etc.)		ace - Americ ack, White,	
Ö	ours a	eted	3 🗆 Widowed 4 🖭 Divorced	If Yes, Give Year or Dates. Viet	Nam		No Specify:			Specif	^{fy:} Wh:	ite
715	in 72 h	Completed	15. Decedent's Educat (Specify only highest grade c	ompleted)	(Give k	ent's Usual O aind of work do NOT use ret	one during most	of working	g	16b. Kind of	Business In	dustry
21,	/giene /giene ner th: t, the		12	College (1-4 or 5+) N/A	H	lairdr	esser			Cos	meto.	logy
Maryland 21215-0036	oe filec intal H ced otl	To Be	17. Father's Name (First, Middle, Last) Jacques Silvers						(First, Middle, $i1$ vers	Maiden Surnar	ne)	
ary	nould but Me s mark		19a. Informant's Name/Relationship (Type, F	Print)	19b Mailin	a Address (St					State Zin (Code 21209
Σ	asalth a n 27 is n 27 is ner tra		Rhea Satren- Mot	her								nore,MD
Baltimore,	Je 1 ar it of He iffiter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem	oval from State 20b. Pl	ace of Dispos emetery, crem	sition (Name o	f place)	Da	ate	20c. Location	- City or To	own, State
謹	nit. Pagartmer artmer ortant injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Squarter of FunantS vice Licensee	Bay			tory			Balti		
Ва	Depar Depar Impor any in		I had spurgered	á								Home,PA MD 21222
		۲	shock, or heart failure. List only one ca	ons that caused the death use on each line.	. Do not ente	r the mode of	dying, such as	cardiac or	respiratory arm	est,		Approximate Interval Between
7	hysician/ Medical	Î	Immediate Cause (Final disease or condition resulting in death)	Sepsis								Onset and Death 2 wtek-s
	Examiner			Due to (or as a consequence of the consequence of t	20 10	which .	\sim					2 weeks
-	р ‡	niner	Sequentially list conditions, if any, leading to immediate rause Enter Underlying	Due to (or as a consequent		10011						
	ecute and l-trans	Examiner	Cause (Disease or iinjury that initiated events c. = resulting in death) Last	Due to (or as a conseque	ence of):							
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928	rtificat ing ph e as th	Med	IF FEMALE:									
P.O. Box 6876	ath ce attend for use	Completed by Physician/Med	in the past 12 months?	f yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 2 ☐ Pregnant at time of de	death 3	Ectopic preg				- 1	ate of delive	ery Day Year
Ö.	g g g	hysi		Unknown		Other (specif			_			
a.	s that gned t	by P	Part II. Other significant conditions contrib	uting to death but not resu	Ilting in the ur	nderlying caus	e given in Part I					ne cause of death?
rds	equire	eted							1 U			oably 4 🗆 Unknown
Division of Vital Records,	e has k	duc							24a. Was a autop perfor	sy	prior to condeath?	psy findings available mpletion of cause of
a H	Physician: The law this certificate has al director, page 2:	Be C	25. Was case referred to medical			2	6. Place of Deatl	h (Check o		med? 2 No	1 Yes	2 X No
Ĭ	hysici nis cer I direc	To E	examiner? 1 Yes 2 No Hosp	ital: 1 Nnpatient 2 🗆 E	R/Outpatient	3 🗆 DOA	Other: 4 🗌 Nu	rsing Hom	e 5 🗆 Resid	ence 6 🗆 Oti	ner (Specify)
υof	ling Pl		1 Natural 5 ☐ Pending		28b. Time of injury	28c. I	njury at work?		d. Describe h	ow injury occur	red	
Sior	Attend death ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At hor	ne farm stre		Yes 2 🗆		of Location /Si	reet and Numi	her or Pural	Route Number,
Σ	talor, rs afte al Dire ed in b		4 ☐ Homicide determined	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	.,,			City or Town		50, 0, 1,0,0	Tioute Humber,
	To the Hospital or Attending Physician: The law requires that the within 42 Hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier (Check only one) 1	In the basis of examination	and/or investi-	gation, in my o	pinion, death occ	curred at th	ne time, date ar	d place, and de	ue to the cau	use(s) and manner stated.
	vithir To th comp	2	29b. Signature and title of certifier			29c. Lic	ense number		2	29d. Date signe	ed (Month, I	Day, Year)
			mo		20-1/7	115	140430	101		Aprili	1,20	211
)			30. Name and address of person who completed Tomic		23a) (Type, Pr	HOSE	to letic	- Bai	Hnor	3, Bal	anti	re MO
	State Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	fark.	1					-	
, DHN	IH 17 Rev 7/200		HELT TO COLL Y	Want -								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Month Physician/ April 19 2:30 A. Harold Leon Sivert Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5359 Irving Ruby Road Sykesville Carrol1 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. Social Security Number Age (In vrs. last birthday) XXM 2□F **Funeral** Ohio Months June Tay, 1920 235-14-3513 90 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State 10b. County death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes XX No Sykesville MD Carro11 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21784 5359 Irving Ruby Rd. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces?

XX Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami once. Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo White Completed 3 Widowed 4 □ Divorced Year or Dates. WW II 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Repair Auto Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Bertha Lee Dukes Daniel Boone Sivert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5503 Weywood Dr. Reisterstown, MD 21136 Kathleen Herr / Daughter 20c. Location - City or Town, State 20a. Method of Disposition
1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4/22/11 Reisterstown, MD 4 Donation 5 Other (Specify) A11 Saints Cemetery 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Signature of Fun Ser, ce License 11605 Reisterstown Rd. Owings Mills, MD 21117 Approximate Interval Between Onset and Death . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or heart failure. List only one caus Immediate Cause (Final Physician/ Medical resulting in death) D to (r as a consequence/of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: perforr 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 D Other (Specify) မ ☐ Nursing Home 24 hours after death.

Funeral Director; After thi leted filled in by the funeral. Manner of D th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending Natural Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifie erson who completed cause of death (Item 23a) (Type, Print) 30. Name d address 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 16. 2011 В. **Physician** See 6:03 A. M Marian /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Keswick Multicare Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 8. Date of Birth (Month, Day, Year) May 31, 1916 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2√□ F 94 214-46-7257 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examire must be redifficated. 10a. State 10b. County Yes 2□No Directo Baltimore Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21211 4012 Roland Avenue Funeral 14. Race · American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ⋧ ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Washington County Schools Elementary/Secondary (0-12) College (1-4or 5+) School Librarian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Chapin Walter Brock ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 208 W. 42nd Street, Baltimore, Maryland 21211 Daughter Rachel See 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4/26/2011 Hagerstown, Maryland Rest Haven Cemetery ²², Name and Address of Facility
Burgee Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland 21. Sign ture of Funeral Service Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. to lower extremiti Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 🗆 Live birth 2 🗆 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 Yes 2 No certificate has been signed by the irector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≽</u> 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown DVA1 hemoway Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes a ☐ No 1 ☐ Yes 2 ☐ No after death.

Director: After this certific
I in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier $n(n_0)$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 CHAVLES SI Don 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Apr. Physician/ D2 011 Harold Spicer 15 5:08 A M Ray Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 543 Trimble Road Joppa 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, 1 🕱 M 2 🗆 F Months Hours Min Marvland Director 215-14-0594 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Harford 1 Yes 2 No Joppa 10e Street and Number 10f. Zip Code 6 10g. Citizen of What Country? event, the Medical Examiner must be Funeral items 23a 543 Trimble Road 21085 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian ed Forces? Yes 2 No Black, White, etc. 1 X Yes If Yes, Give ģ 1 Never Married 2 X Married than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Self Employed Stone Mason Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Elmer Spicer Ella (unk) Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 543 Trimble Road, Joppa, Maryland 21085 Virginia Spicer / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp: 04-19-11 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licens 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ End Stage disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Diasete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) /sician and Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No , page 2: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No funeral director, 26. Place of Death (Check only one) Be Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? iniury 1. Natural 5 Pending Accident death. Investigation completed filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License numbe 29d. Date signed (Month, Day, Year) D438 15

DHMH 17 Rev 7/2009

OXI

State Registrar MB, 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-02834 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Nicholas Shkor State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Shkor **Medical Examiner** Nicholas April 13, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Sinai Hospital 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** oreign Country) Maryland Min. Months Days Hours Director 219-28-4130 January 16.1932 79 1X M 2 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County Ifimore, MD 21215-0036

iit. Pages I and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hygener or or of Health and Mental Hygener or or or items 23s or 28s-f show or other transmitie event, the Medical Examiner must be notified at once, Maryland Baltimore Edgemere 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 21219 3106 Grace Road ö Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White, etc. 1 Never Married 2 X Married 1 X Yes Specify: White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 百 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) Sheriff's Department 11 years Com 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Shkor Anna Strygelski Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ۵ 3106 Grace Road, Edgemere, Maryland Isabele Shkor 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State April crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Elkridge, Maryland Cathedal Gardens 18, 2011 4 Donation 5 Other Specify 21. Signature of Funeral Service ²² Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Pary 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician ure. List only one cause on each line. /Medical a Intracranial Hemorrhage ediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of) b. Ruptured Cerebral Aneurysm Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit d Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Þ pleted this certificate has been s I director, page 2 should 24a. Was ar autopsy this certificate has performed? death? Com ✔ Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner? Hospital: 1
✓ Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pending hours after death. filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined 4 ___ Homicide

2040 hrs

10d. Inside City Limits

1 Yes 2 No

21222

Approximate Interval

Between Onset and

Death

Year

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of 1 🗸 Yes 2 No Other Nursing Home 5 Residence 6 Other To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Sal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E April 14, 2011 elis 30. Name and address of person who completed cause of death (Item 23a) 0) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR Registrar **ORIGINAL** DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Day 2011 17 P M Mary Katherine Snoots 1:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Montgomery Gaithersburg If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Min. September 21, 1912 579-34-5523 98 Virginia Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Montgomery Maryland Gaithersburg 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 425 N. Frederick Avenue #4B 20878 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 ₩ Widowed 4 □ Divorced Specify: Completed White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicall once." 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Grocery Clerk Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Eugene Wenner Mary Odell Fry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald L. Snoots / Son 4 Sassafras Lane, Harbeson, Delaware 19951 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) April 21,2011 Rockville, Maryland Signature of Funeral Service Lice Robert A. Pumphrey Funeral Home/Rockville, Inc. g. shr M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Years Immediate Cause (Final Physician/ Parkinson's Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 5 Years Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 X No Month Dav Year 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 124 hours after death. Funeral Director: After this certificate has been sign 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No page 2 No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 X No Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 X Natural 5 Pending injury work 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29c. License number D31362 man

DHMH 17 Rev 7/2009

State

Registrar

Baltimore,

Box 68760

Division of Vital Records,

32. Registrar's Signatur

501 N. Frederick Avenue, Gaithersburg, Maryland 20877

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

Marlene Hayman,

APR 19 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ April 13, 8:05 Rache1 Smith Lorraine Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Montgomery Hospice Casey House 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea October 20, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Funeral Hours 1 🗆 M 2 🗓 F Months Days Colorado 91 Director 521-16-6744 1919 Usual Residence of Decedent or 28a-f show 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Rockville 1 X Yes 2 No Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20851 United States 2302 Veirs Mill Road "natural", or items death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify.White 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Bookkeeping Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clarence Berton Boddy Alice Wilhemina Terry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra 1609 Marshall Avenue, Rockville, Maryland 20851 Zack / Daughter Judith 20a. Method of Disposition
1 ☐ Burial 2 🄀 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Montgomery crematory or other place) Crematorium, Inc. 20c. Location - City or Town, State Apri $\overset{ extstyle extstyl$ 4 Donation 5 Other (Specify) 2011 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. elles annus M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Dart 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or finjuly that initiated events ing physician ar e as the burial-t resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Po Month Year Other (specify) Dav Pregnant at time of death Yes detached g | I Inknown g 🗌 Unknown signed by: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? page this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital Other: $_{4}$ \square Nursing Home $_{5}$ \square Residence $_{6}$ \times Other (Specify) \bowtie Hospice 1 ☐ Yes 2 💢 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 🔀 Natural 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After (Month, Day, Year) injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No. M Investigation 24 hours after death the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signatur and title 29d. Date signed (Month, Day, Year) 29c. License number R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20855 Debrah Miller, CRNP 32. Registras Signa State Registrar

/DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 State of Maryland / Department of Health and Mental Hygiene

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- 1	- Street	No.	- 6	45

		I- For State Registrar				Certific	ate of	Death	<u>' </u>				Reg. No.		
Physicia		Decedent's Name (First, Middle, Last) Descendent's Name (First, Middle, Last) Day											Year	3. Time of Death	
ledical Exami		Donna	Smith									April 17,	2011		1310 hrs
		4a. Facility Name (if not institution			umber)		- 1	4b. City, To	own, or Lo	ocation of				unty of Dea	ath
		124 Highland Road	-					Glen E	Burnie				Ann	e Arunde	el
		Social Security Number	6. Sex		7. Age (In	yrs. last bir	thdav)	If Unde	r 1 Year	If Under	24Hrs.	8. Date of 8	irth (MM/DD/	YYYY) 9. 8	Birthplace (State or
Funeral			o, sex			, , i 3. i a 3 i bili	uuy/	Months	_	Hours	Min.			Fore	eign i
Director	- [220-66-6201	1 M	2X F	55		Yrs					6/5/	1955		Country) Maryland
	ŀ	Usual Residence of Decedent													10d. Inside City Limits
amy		10a. State 10b. County			100	. City, Town	or Locat	ion							
.	اي	Maryland Anne	Arun	de1		Glen B	Burni	e							1 Yes 2 No
Aaryland 28a-f show 1 at once.	용	10e. Street and Number						10f. Zip	Code				10g. Citizen	of What Co	ountry?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23s or 28s-f sh matic event, the Medical Examiner must be notified at once	Director	124 Highland	2024						1060				TT	SA	
th the M 23a or 2 notified								1			0/0:				erican Indian, 8lack,
with ms 2	Funeral	11. Marital Status		Was De Armed F	cedent Eve	er in U.S.	13. Wa	as Deceder es, specify	nt of Hispa Cuban.	anıc Origir Mexican, F	n / (Spec Puerto Ri	cify Yes or N can, etc.)	14.	White, etc.	encali indian, diack,
r ite	Š	1 X Never Married 2 N	arried 1	Yes	2 🗓	No						,			
fter (3 Widowed 4 Di	vorced if Y	res, Give Ye			1	Yes 2						ecity: Wh	
irs at	d b	15. Decedent's Education (Spe			de comple	ted) 16a.	Deceder	nt's Usual (Occupatio	on (Give ki	nd of wor	k done	16b. Kind	of Busines	s/Industry
2 hou	Completed	Elementary/Secondary (0-12)		College (1-4 or 5+)		during m	ost of worl	kıng life. [DO NOT U	se retired	4)			
36 lical	쁿	12				E	Barte	nder					Food	& Be	verage
with With Mes	Ę	17. Father's Name (First, Middle	l set)		_				11	8.Mother's	Name (F	irst, Middle	, Maiden Sur		
F Hyg		Elmer Matthew		h							•		hanna		iann I
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be					122	Dh. Marilia	a Address	(Shear)						ate, Zip Code)
ould Mid Mit	욘	19a. Informant's Name/Relation Mrs. Katherine			/Ma+1								nie, M		
MD and 2 sho at 2 sho alth and a 27 is			. J.	וודנו	1/ FIU L1										or Town, State
ore, MD 21215-00 (ss. 1 and 2 should be filed with of Health and Mental Hygien If item 27 is marked other traumatic event, the Menter traumatic event		20a. Method of Disposition		_		20b. Place crema		sition (Nam her place)		etery,	Apri	1 25	ZUC. LOC	adon - City	or rown, state
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours af ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural or other traumatic event, the Medical Examin		1 X Burial 2 Crematic		Removal f	rom State	Glen					20		G1e	n Bur	nie, MD
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_		30. Name and address of person	My /	mpleted co	use of dea	th (Item 23a	1)								
		Pamela E. Southall,				al Examin		11 Penr	Street	t, Baltim	ore, M	D 21201			
	tate	31. Date filed (Month, Day Yea	011	32.	Registrar's	Signature	BALR	1							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 19:32M Apri Physician/ Beverly L. Switzer 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Baltimore hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Aug 10 ^{Year} 1941 Days Min. 1 □ M 2 🛛 F Maryland 69 Yrs. 217-40-8888 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a. State Director 1X Yes 2 □ No Maryland N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21229 USA 1111 Cooks Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 - Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) College Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel M. Utz George F. Switzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2907 Riviera Drive Kev West, FL 33040 Todd M. Switzer 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory Inc. 04/15/11 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor ²Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ cene tobactor pheumonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury physician and is the bunal-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical ivision of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 Vo
9 Unknown Month Year Pregnant at time of death 9 Unknown sate has been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ renal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 👿 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Bishow

31. Date filed (Month,

900 S

04-14-2011

Caton Ave Baltimore city, MD 21229.

Medical Kerident

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chandra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day :15 am **Physician** 2011 kandolph PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

AD 1 1 5 1955 Homores burtland Gard Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** April 1 M 2 F 218-62-2808 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "natural" ---- any injury or other traumatic average. 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 1 Tes 2 No altimore Director Itimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21244 SA 920 by Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 10 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sable 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be rown cott ပ Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21228 Kague + mae 1acqueline barrism-Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 Cremation 3 □Remøval from State 20/2011 4 □ Donation 5 □ Other (Specify) odlawn t Uneral Service Light see 22. Name and Address of Facility Howell Heighti Balto. MD 21207 21 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) omonths irrhosis Physician /Medical Due to (or as a consequence of): **Examiner** Marks 0110 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as ayeonesquence of): Examiner led by the attending physician and detached for use as the burial-transit be executed Due to (or as a consequence of): Records, P.O. Box 68760; Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown nis certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
1 Yes 2 No this certificate has of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 X No 1 Inpatient 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA completely filled in by the funeral 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day 28b. Time of Certification; After Division 5 Pending investigation 1 Natural 2 No death. 1 🔲 Yes 2 Accident after death Director: 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospitel or 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2. To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature who completed cause of death (Item 23a) (Type, Print)

Or COYOUN (TUNP 6095 N 2 6095 Marshalee Dr. Elkridge, MD 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 201 2046 PM ACO(Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Northwest Hospital Center Randallstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Country) 0 19 21 920 WV 90 Director 235-14-8512 Usual Residence of Decedent fshow ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 XNo MD Baltimore Catonsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21228 U.S.A. 1302 Black Friars Court 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Specify: white 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Susanna Stowers Grover C. Helmick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Page 1 and 2 strength of Health a tant: If item 27 is 1302 Black Friars Ct.; Catonsville, MD 21228 Thomas M. Tawney/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakeview Mem 1 Park 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 04-19-2011 Sykesville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Sterling Ashton Schwab Witzke uneral Home of Catonsville, Inc. 630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ GROVARY ATHEROSCIENOTIC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the 38 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown for Month Pregnant at time of death 5 Other (specify) g Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform certificate 1 Yes 2 No To the Lospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, p. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ted cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year) APR 1 9 2011 ROAD

OUD COURT

RANDAUSTOWN.

5401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harriett Townsend 2011 11:49 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3809 Elmley Baltimore na Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗙 F Days 214-62-7823 Hours 58 Director Usual Residence of Deceden or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21213 USA **Examiner must** 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc or i 1 Never Married 2 Married Completed by Yes, Gi Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. Black 3 Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) conday (0-12) Solo Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John pgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3809 lownsend - Daug Monique 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) ansdown, 21. Signature of Juneral Service Licensee 22. Name and Address of Facility March East Balto, 21202 1101 E. North Avenue MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine use as the burial-transit and Due to (or as a conseque attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal deat 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 📝 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Physician/ 2011 17 5;50A Elizabeth Unger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium Balto. Stella Maris Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** Day, Year) her 27,1920 Min Russia 1 🗆 M 2 🔀 F Months Days Hours 90 Director 216-36-5956 November Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Balto. Kingsville Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 12 Ridgecliff Court 21087 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 2 X No þ Yes Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates Specify Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5:50 Seamstress Clothing Manufactor Be Department of Health and Mental Inportant If item 27 is marked oth any injury or other traumatic averages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jacob Rosenbach Elizabeth Bretz 2011 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Kupres DTR. 12 Ridgecliff Court Kingsville, Md. 21087 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State 4-20-2011 Baltimore Balto. Md. 4 Donation 5 Other (Specify) Schimunek FuneralHome 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Buen al 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ HEAD AND NECK CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕷 No Day Other (specify) Pregnant at time of death page 2 should be detached ELIZABETH UNGER signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) ဂ္ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred iniury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

【Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29d. Date signed (Month, Day, Year) 2 ess of person who completed cause of death (Item 23a) (Type, Print) JONES, 2300 DULANEY **JACKIE CRNP** VALLEY RD. TIMONIUM, MD 21093 32. Registrar's

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 April 17, Francis N. Viscardi 4:30 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Date of Day, (Month, Day, Days 1 X M 2 □ F Months Hours Min. Director New York 061-14-6036 88 1923 Jan. Usual Residence of Decedent shov 10a. State 10b. County with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a edical Examiner must be Funeral 6109 Wheatland Road 21228 USA death v 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 White 1 ☐ Yes 2 2 No Specify: 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Insurance Representative Knights of Columbus Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anthony Viscardi Antoinette Bonnano Department of Health and Important: If Item 27 is me any injury or other traumagone. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne M. Viscardi Wife 6109 Wheatland Road; Baltimore, MD 21228 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Garrison Forest VA Cem 4/21/2011 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses MOIDSO J 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ BLADDER CANCER Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Cause (Disease or injury that initiated events burial-tra resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Records, P.O. Box for Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 9 Unknown 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy perform<u>e</u> of Vital funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Certificate: 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After 1 X Natural injury 5 Pending **Division** Accident Investigation completed filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APRIL

FRANCIS VISCARD

State Registrar

JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. 31. Date filed (Month, Day, Year) APR 9 20

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Charles 01iver Vanskiver 9:05P M 04 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Queen Annes 602 Buckingham Drive Stevensville . Age (In yrs. last birthday) Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year) 12/27/1930 Country) Months Davs Hours Min 1 X M 2 - F Director 218-26-7438 80 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits at 10c. City. Town or Location Director notified 1 Yes 2 X No MD Queen Annes Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or idical Examiner must be r Funeral with 1 602 Buckingham Drive U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3X☐ Widowed 4 ☐ Divorced White Completed Year or Dates d Mental Hygiene.
marked other than "natur
matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pipefitter Western Electric Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ William Henry Vanskiver Catherine Rosalie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert Vanskiver Phelps Avenue Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park: 04/18/2011 Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light Interval Between Onset and Death arkinsons Immediate Cause (Final Dis eace Physician/ disease or condition resulting in death) 1295 Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached the Unknown P.O. sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform ua setes 1 Yes 2 No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🗌 Nursing Home 5 🗗 Residence 6 🗌 Other (Specify) Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 | No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Ny practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa 037064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stevens ville 21616 5-11,4 115 MD Mams & Con 31. Date filed (Month, Day, Year) State 1 9 Registrar

12527

			State Registrar			ertificate of D	eath	F	Reg. No.	
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	Funeral Director	- 1		MM 2□F	72 Yrs	Months Davs	Hours Min.	(Month, Day October	10, 1938	ountry) T e xas
			Usual Residence of Decedent							
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	th the	alD	10e. Street and Number	- "		10f. Zip Code	0001/		10g. Citizen of What 0	
	ms 2	Funeral Director	4925 Battery	12. Was Decedent Ev		3. Was Decedent of His	20814 Spanic Origin? (Spe	ecify Yes or No-	United 14. Race - Am	
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<u></u>	urs after death with the Maryland rral", or items 23a or 28a-f show i Examiner must be notified at	ed k	3 ☐ Widowed 4 🂢 Divorced	If Yes, Give Year or Dates. U i	- 1	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
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e,	of He fitem	1	20a. Method of Đisposition 1 ☐ Burial 2 🔀 Cremation 3 ☐	Domewal from State	20b. Place of D	isposition (Name of crematory or other place	Apri	Pate 18,	20c. Location - City	or Town, State
Ĕ	Page ment ant: I ury o		4 Donation 5 Other (Specif		Crema	crematory or other place gomery torium, Inc	20)11	Bethesda,	Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nan in any injury or other traumatic event, the Medical is once.		21. Signature of Funeral Service Licen	ee ···································	M01360	Robert and Address 7557 Wiscons	in Avenue.	eral Home Bethesda	/Bethesda-Ch Maryland 20	evy Chase, Inc. 814-3501
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	E>E0		170mg/4	Allan	OFAC	' н4	5839		April 15	, 2011
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Ty	pe, Print)				
2-1	rl		Gary E. Raffel,			dar Lane Su	i ite #203	C, Beth	esda, Mary	land 20814
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_				State Registrar				Cer	tificate c	of Death	7		Reg. No.	JII	2 51349
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		Funeral Director		5. Social Security Nu. 214-26-50		ex 7. Ag	je (In yrs. la 80	st birthday) Yrs.	If Under 1 Y Months D	ear If Unc ays Hours		8. Date of Birtl (Month, Day Dec. 30	, Year) 193	9. Birth Coun Mary	place (State or Foreign try) r Land
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	death with the Maryland	Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		6028 Blac		s Circle				.228			USA		
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0/30		sician/ Medical		23a. Part 1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List only o Final	plications that cause one cause on each lir a. Due to (or as	16. 5Снь	n. Do not ente	er the mode of	dying, such	as cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
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D(ertific 5	ding page as	W/	IF FEMALE:		23c, If yes, outcome	e of pregna	ncy					23	d. Date of deliv	verv
700	ath ce	attending physi	Physician/Medi	23b. Was decedent in the past 12 r 1 Yes 2	months?	1 Live Birth 4 Pregnant	2 Feta	Ideath 3	Ectopic pred Other (speci				20	Month	Day Year
	he de	y the	hysi	9 Unknown		9 🗌 Unknown									
Meivin		signed by the a I be detached f	Completed by P	Part II. Other signif	icant conditions	contributing to death	but not res	ulting in the u	inderlying cau	se given in P	art I.				he cause of death?
Se	requi	been sig	ete									24a, Was	an [24b. Were auto	psy findings available
(The law requires	s certificate has b lirector, page 2 s	dwo									autor perfo	osy rmed2	death?	ompletion of cause of
	. =	ificate or, pa		25. Was case referre	ed to medical					26. Place of I	Death (Check	1 \(\sum \) Yes	2 No	1 L Yes	2 140
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7 3	Ph Ph	er this		27. Manner of Death		28a. Date of in	ury	28b. Time o		Injury at work?		28d. Describe h			
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	o the	within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Σ	only one) 3 29b. Signature and		rse Practioner: To th	e pest or my	y Kilowieage,		cense numb		c, and use to th		signed (Month,	
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Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ (0:47 a M 2011 William W. Wellman Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Death **Examiner** Kenry Point eci Ja I Karyland Health Cure System 9. Birthplace (State or Foreign Country) West Virginia If Under 24 Hrs. 8. Date of Birth (Month, Day, May 10, Social Security Numbe 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year-**Funeral** Min 218-46-6903 1948 62 May Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State Director 1 ☐ Yes 2X No MD Catonsville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 Funeral 331 Stafford Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates Physician; Wellman, William 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Construction Zone College (1-4 or 5+) Elementary/Seconday (0-12) Safety Equipment Regional Sales Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Flannigan James Wellman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Wellman 331 Stafford Drive; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Glen Haven Cemetery 4/23/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee M01050 1tada Approximate Interval Between Onset and Death 23a. Part 1. Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ aero ginula Due to (or as a consequence of): and pheumonic disease or condition resulting in death) Medical Examiner Keshiraho Nameknownto Sequentially list conditions. Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Amyotrophic Cause (Disease or linjury use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician a be detached for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Dav Year Month Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XÛnknown Dulmonas Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has performed? Yes 2 XNo To the Maspital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1. **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sod 1942014 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Va Maryland Health Care Septem Perry Point MD 240 Durinderpal 31. Date filed (Month, Day, Year) 32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

State Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 6 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Genesis Perring Parkway Center Parkville 8. Date of Birth (Month, Day, Year)
July 22, 1946 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Hours Min. Months Days 1 □ M 2 X F West Virginia 64 Director 214-52-9277 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State show ral", or items 23a or 28a-f shov Examiner must be notified at Nottingham Baltimore 1 ☐ Yes 為☐ No MD Directo the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or? 21236 9540 Hickory Falls Way USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 ☐ Divorced f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Rummel, Klepper and Kahl Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary RK and 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Belle Kramer Brown Miller ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 9540 Hickory Falls Way-Nottingham, Maryland Ronald Willet-son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place).

TVans Funeral Chapel and 20a. Method of Disposition permit. Pages
Department of
Important: If It
any Injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State April 19,2011 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sar Pelair Cremetion 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Condition **Physician** gressine disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner emic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or consequence of): Division of Vital Records, P.O. Box 68760, physician nronic Physician/Medical attending physical for use as the b 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No psy ent arcole 25. Was case referred to edical examiner? funeral director, Be 1 AC In C 26 ce of Death (Check only one) 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 201 1087625 30. Name and address of person who completed cause of death (Item 23a) (Type Print) ma

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Genera B. Jacks ORIGINAL

11-02924 Christina Lynn Wells

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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		For State			Certific	cate of I	Death				Reg	g. No.		
Physician		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1.759 hrs												
Medical Examine		Christina Lyr	n Wells							A	pril 17, 20)11		1759 Nrs
	4	la. Facility Name (if not institution	on, give street an	d number)			City, Tow	vn, or Lo	ocation of	Death		4c. County of		'e
		Bowie Health Center					Bowie		K11: -1:	2411= 10	Date of Di-	(MM/DD/YYYY		
Funeral		5. Social Security Number	6. Sex	,	n yrs. last bi	irthday)	If Under 1 Months	Days	If Under Hours	Min.			Foreign	1
Director		214-92-5806	1 M 2 X	F 3	2	Yrs.					10/25,	/1978	Cou	mtryMaryland_
b	_	Usual Residence of Decedent Oa. State 10b. County		110	City Tow	n or Location	n							10d. Inside City Limits
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Maryland 28a-f show d at once	<u> </u>	MD Howa	ara		Elkri		10f. Zip Co	nde .	_		10	g. Citizen of Wh	at Coun	trv?
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death with the Maryland or items 23a or 28a-f sho must be notified at once.		6502 Fallstor		Decedent Ev	or in IIS	13 Was	210		anic Origin	n? (Specif	y Yes or No-		- Americ	can Indian, Black,
r death with , or items 23	2	l1. Marital Status 1 ☑ Never Married 2 ☑ M	arried Arme	ed Forces?		If Yes	s, specify (Cuban, N	Mexican, I	Puerto Rica	an, etc.)	White		
er de:			1 1 orced If Yes, Give	es 2 🛚 X e Year	No	1 🗆 🗎	res 2X	No	specify:			Specify:	Whi	te
5-0036 de within 72 hours afthe de within 72 hours afthe description of the relational Examine from placed Examine from placed by	⋛├	15. Decedent's Education (Spe	or Dates:		ted) 16a	. Decedent's	s Usual Oc	cupatio	n (Give ki	nd of work	done	16b. Kind of Bu		
2 hou 2		Elementary/Secondary (0-12)	Colleg	ge (1-4 or 5+)		during mos	st of workin	ng life. D	OO NOT u	ise retired)				
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other M	3	17. Father's Name (First, Middle	, Last)		•		•	18	3.Mother's	Name (Fir	rst, Middle, M	aiden Surname)	,
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		James Michael										rquist		
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imore Pages 1 nent of H hant: If i or other	1	4 Donation 5 Other S	pecify:		West	Arund						Odento		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mendal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once T De Commissed by Elinoral Director	Γ	21. Signature of Funeral Service	Licensee											me, P.A.
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ntifica ring pl as th	- 14	3b. Was decedent pregnant in t past 12 months?	the 1 L	ive birth		2 Feta	al death	3	Ectopic	pregnancy	•	Month		ay Year
Box 68760, e death certificate be the attending physic ed for use as the bur	2	1 Yes 2 No 9 ✔ Ur		Pregnant at tim	e of death	5 Oth	er (Specify	y)				, l		
Vital Records, P.O. Box 68 sysician: The law requires that the death certifies his certificate has been signed by the attending director, page 2 should be detached for use as	ا≤	Part il. Other significant condi	3 0	Inknown	ut not result	ting in the ur	nderlying c	ause div	ven in Par	rt I.	23e. Did to	bacco use contr	ibute to	the cause of death?
that the by detac	à	rait ii. Other significant condi	done contribut	ing to death b	at not room	ang in are a	.comyg	and g.			1 Yes	2 No 3	Prob	ably 4 Unknown
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aw relate to the same of the s	ompleted										autop: perfor	med?	death?	completion of cause of
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Physical Arter this all directions of the physical directions of the physic	<u> </u>	1 ✓ Yes 2 No	''			/Outpatient b. Time of In			at Work?			now injury occur		
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DIVI III or A	Certification:	det	uld not be	ecify) Majo	-		, , , , , , , ,	J00 E.				tate) Route 50, Bow		
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Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as a	<u>8</u>	(Check only one) 2 Medical Ex	aminer: On the b	asis of exami	nation and/o	or investigati	on, in my o	pinion,	death occ	curred at th	e time, date	and place, and	due to th	e cause(s)
To with To con	Medical	29b. Signature and title of certif		ner stated.			29c.	License	number			29d. Date sign	ned (Mo	nth, Day, Year)
		Down of Reach	will mi	٦				O.C.N	И.E.			April 18, 2	011	
	-	30. Name and address of perso	n who completed	cause of dea	th (Item 23a	a)						i		
e		Pamela E. Southall,		ant Medica			Penn S	Street,	, Baltim	ore, MD	21201			
Sta	te	31. Date filed (Month, Day, Year) / 3	32. Registrar's	Signature	Nas								
Registr	ar	APR 1 9 2011	Decens	U B.	Loan	Kant								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2, Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Virginia Rosalee White 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury Coastal Hospice at the Lake Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min Oct II 1 🗆 M 2 💢 F West Virginia 1920 Director Yrs 90 234-22-533] Usual Residence of Decedent n and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State should be filed within 72 hours after death with the Maryland Director 1 Yes 2X No Laurel MD Prince George 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20708 8804 Enfield Court #24 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Virginia Unit 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 X Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) United States College (1-4 or 5+) Elementary/Seconday (0-12) Government Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Amonte Gertrude Roeder John Young item 27 is marke other traumatic ..d2 Health an m 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 201, Old Westover Road, Westover, MD 21871 Page 1 and 2 Diana E. Beckett / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it tof 1 X Burial 2 Cremation 3 Removal from State Ivy Hill Cemetery Apr 18, 11 Laurel, Maryland 4 Donation 5 Other (Specify) 22 Name and Address of Facility Donaldson Funeral Home, 313 Talbott Ave. Laurel, Signature P.A. Maryland 20707-4389 M00773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC ULMONARY Ph_sician/ BSTRU disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Year Month Dav Pregnant at time of death 5 Other (specify) detached 9 Unknown P.O. cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 certificate has 2 10 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 21 No Other: 4 Nursing Home 5 Residence Other (Specify) မှ ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate; Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.V BOP e Huram WARY 31. Date filed (Month, Day, Year)
APR 1 9 2011 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12ª April 1 3:26 PM Physician/ 20^YP^a1 Ellen Wisniewski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Eastwood 6933 Bank Street 5. Social Security Numbe If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🔀 F Months OCC 244, 1957 Maryland 53 215-52-3309 Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Eastwood Baltimore Md. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21224 6933 Bank Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. White "natural", 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Johns Hopkins d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Bayview Medical Ctr Registrar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Vera Pasek Bernard Ruzin _____ 19a. Informant's Name/Relationship (Type, *Print)*Husband and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra 6933 Bank Street Baltimore, Maryland21224 <u>Chester A. Wisniewski</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Rosary Cem 20c. Location - City or Town, State 20a. Method of Disposition Aproiate 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 15,2011 |Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Dundalk Avenue Baltimore, Md21222 1201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final stage I meast cancon Physician/ Metastatic montas disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner coaculopath Dissemnated (utravasculai Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine 12 years or Attending Physician: The law requires that the death certificate be executed ţ Breast cancor Stage attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death Unknown the a 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has b autopsy page 2 performed? death? 1 ☐ Yes 2 ☐ No this certificate 1 🗌 Yes 2 🔽 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🎛 No Other: 4 Nursing Home 5 KResidence 6 Other (Specify) ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death.

I Director: After to in by the funera Certificate: X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) within 24 hours a

To the Funeral D Hospital Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MA D 58893 April 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Ilene Browner, M.D. 4940 Eastern Avenue, Allo Baltimore, Md. 21224

State

Registrar

31. Date filed (Month, Day, Year)

9

37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Washington 11:45a^M Chester Alphonsus James 04 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9401 White Cedar Dr. Apt 215 Owings Mills Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Min. Hours Country) 219-42-9549 Director 66 05 09 MD Usual Residence of Decedent or 28a-f show e notified at filed within 72 hours after death with the Maryland al Hygiene.
1 other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Owings Mills 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9401 White Cedar Dr. Apt 21117 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces' Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, City Elementary/Seconday (0-12) College (1-4 or 5+) nstrumental Music Public Schools grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental F item 27 is marked of 27 is marked or traumatic eve ည Joseph Washington Christine White 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 9401 White Cedar Dr. Apt 215, Owings Mills Joyce Dorsey Washington item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State . Page 1 permit. Page 1
Department of
Important: If it
any injury or o ð 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial 4/18/2013 Park Woodlawn, Md 21. Ignati te of Funeral Service Licensee 22. Name and Address March F/H of Facility West 4300 Wabash Pirt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Tuocar Medical onsequence of): Due to (or an a Examiner C Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury ending physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home Residence 6 \square Other (Specify) Hospital မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined in 24 hour. Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 🤊 29c. License number 29d. Date signed (Month, Day, Year) 25112 04/13/2011 OWINGS HILL knowno completed cause of death (Item 23a) (Type, Print) oad S Drive Suite 101 30. Name and address of per Kawaia Tahoora 31. Date filed (Month, Day, Year) 32. Registrar's Signature State rack APR 1 9 2011 Registrar

/DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 State of Manyland 1/19/2011 and Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month :00A M Medical 4a. Facility Name or Location of Death 4c. County of Death Examiner lttmore Hor If Under 24 Hrs 9. Birthplace (State or Foreign last birthday ate of Birth **Funeral** Days Months Hours Min **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 **№**es 2 🗆 No 10e. Street and N 109. Citizen of What Country? Funeral Koad 21229 mtord Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 6 o Specify 3 Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education cify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) hday (0-12) College (1-4 or 5+) Be rst, Middle, Last) ပ emmons Informant's Name/Relationship (Type, City or Town, State, Zip Code) od of Disposition 🔑 Burial 2 🗌 Cremation 3 🔲 Removal from State MU 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se 23a. Part 1. Enter the disease, or shock, or heart failure. List of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: completed filled in by the funeral director, page 2 should be detached for use 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 [Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signatu 世〇〇 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month () I+ Physician/ Wilson Norris Elmer 201 6:010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner timore Rosedale Franklin Sauare Hosp 9. Birthplace (State or Foreign Year If Under 8. Date of Birth If Under Age (In yrs. last birthday, **Funeral** (Month, Day, Year) 02/04/1941 Country)
Maryland Min. 1 Q M 2 □ F ш 70 **Director** 218 40 1240 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 0 11 1 🗌 Yes 2 🙀 No Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Z 21221 USA 201 S. Taylor Avenue 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) WILSON, 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 21215-0036 1 ☐ Yes 2 ☐ No Year or Dates. 1963–69 Specify. Specify: white 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the and injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) warehouseman bakery Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Zorada English Still Theodore Alexander Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Evelyn Karen Ford (daughter) 201 S. Taylor Avenue Essex Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Glen Burnie Maryland 4/16/2011 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory IJC ral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Death 23a. P t . Enter the dis shock, or heart failu med ate Cause (Final Physician, espiratory Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Yes 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Hospital: 2 🗹 No မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 27. Manny of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 - Natural 5 Pending 1 Tes 2 No death. 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number RESODOO 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square DR. Jessica Stinnette, Balto. MD. 21237 MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 19 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month Physician/ 04 2153 2011 DEBORAH R. WEATHERS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE MD GOOD SAMARITAN HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min. 08/12/1954 1 🗆 M 2 🖵 F Marvland Director 56 213 62 3436 Usual Residence of Decedent shov 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland notified at Director 28a-f 1 Yes 2 No Maryland Baltimore Middle River 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i Funeral United States 834 Lannerton Road 21220 permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Evaminar m... Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐ Yes 2 ♣ No Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Care giver Davcare Center Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ Shirley Dallas Henderson Norman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 834 Lannerton Road Middle River, Maryland 21220 19a. Informant's Name/Relationship (Type, Print) Stephen Weathers (husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory LLC 4/18/2011 Glen Burnie Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21 Si Funeral Service Licensee 1407 Old Eastern Avenue Essex Maryland Palt 1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician/ INTRACRANIAL BLEEDING Hours Medical resulting in death) Due to (or as a consequence of) Examiner Years HYPERTENISION Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Diabetes melitus No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic kidney disease page 2 autopsy After this certificate has performed 1 🗌 Yes 2 🗌 No 26. Place of Death (Check only one) Be (25. Was case referred to medical funeral director, examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural Natural 5 Pending 2 🗌 No Accident Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check The basis of examination and a state of the basis of examination and a state of the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04/15/2011 RESODO M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD SURAJ TIMIL SINA 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

/ DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nrigh Aori 1:20 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hora 8. Date of Birth

Month, Day, Y . Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) **Funeral** 1 M 2 🗆 F **Director** Usual Residence of Decedent Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 1 Ves 2 No 21th more 10e. Street and Number 10g. Citizen of What Country? **Completed by Funeral** 2120 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 21215-0036 1 Yes 2 No Specify: Black. Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Self Employee 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Window .mplovled Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) Unk 18. Mother's Name (First, Middle, Maiden Surname) =va 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wright Brook exington. Circle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 remation 3 Remoyal from State Cremation 5 Other (Specify) S' atur I neral Service Liter ee towell Heights 21207 Approximate Interval Between Ons. and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final ∳hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for sela consequence on cause. Enter Underlying Cause (Disease or linjury for use as the burial-tran signed by the attending physician and that initiated events Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 687 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Year Month Pregnant at time of death 9 Unknown should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 21 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy completed filled in by the funeral director, page 2 performed? alcohol use certificate | Yes 2 No 1 🗌 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Hospital: oseph Wiakt 20 No TOSPIA 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this 28b. Time of injury 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the 29d. Date signed (Month, Day, Year) ൧ 2011 Karkine Havism Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto MD. 21201 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 DVI Medical Name (if not institution, give 4c. County of Death street and number 4b. City, Town, or Location of Death **Examiner** 4a. Facility soutimore HOSPIC WSor If Under 24 Hrs. If Under 8. Date of Birth 9, Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 34-2810 1 □ M 2 🕶 Months Hours Min - Yrs. Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 No notifie LMY 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 2101 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0. 1 Never Married 2 Married þ 2 100 1 Yes If Yes, Give 21215-0036 1 Yes 2 No Specify Specify: "natural", 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Mortion traumatic event, the 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be fill ment of Health and Mental tant: If item 27 is marked ည \cap 19a. Informant's Name/Relationship (Type, Print) 21045 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra Wil William 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 1 Surial 2 Cremation 3 Removal from State MD rownsville rownsville 4 Dorration 5 Other (Specify) 2011 Funeral Service Lice Funera Home 22. Name and Address of Facility 20194 23a. Part 1. Enter the disease e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Cervica days Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Dire for as a consequence on burial-transit Cause (Disease or iinjury 5 that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ō in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Yes 2 No Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ᇛ 2 🗌 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) + 5 ○1 ℃ € 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending ☐ Natural Accident s after death. PM 4/7/11 30 1 Tyes 2 No tell down Stairs Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Baybian WS+, loumbin, MD Home 6099 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 10634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buchmere, MO 10 Charles

State Registrar 32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ APPIL 2811 Wark Dean Myra Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne CIEN JUSING. neuro SALTIMORE WASHINGTON MEDIUM CENTS If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. 09-26-1920 Months Hours 1 M 2XXF 215-12-1717 PA 90 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Tes 2 X No MD Anne Arundel Annapolis 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral United States 21409 84 North Old Mill Bottom Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 ☐ Yes 2 🗓 No Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home maker Own Home Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည Pauline Ailes Byrul Dean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 113 Kings Court, Centreville, Maryland 21617 Karen Hansen - granddaughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem Park |04-15-2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service MMP, Inc, 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Doe to (o Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi signed by the attending physician and the detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant a 9 Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director; After this certificate has performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pendina 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29b. Signat 2011 completed cause of death (Item 23a) (Type, Print) 3 and address of person who

DHMH 17 Rev 7/2009

State Registrar 32. Regis

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			For State Registrar	State of Maryland		artment of F		F	leg. N2 ()	An administration	12541
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	Examir	ner	4a. Facility Name (if not institution, given Johns Hopkins Ba		T 20		Location of Death	1			
	Funeral Director		5. Social Security Number 6. S 206–10–9609			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, August	Year)	9. Birthpla Country	ace (State or Foreign y) yland
	Maryland 28a-f show etified at	Director	Usual Residence of Decedent 10a. State Md. Bal:	timore 10c. City, 7	Town or Lo		dalk			10	d, Inside City Limits 1 ☐ Yes 2 🙀 No
	n with the is 23a or 3	Funeral D	10e. Street and Number 6902 Delvale	Place		10f. Zip Code	21222		10g, Citizen of	What Counti USA	y?
9003	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 承 No If Yes, Give Year or Dates.		 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify: 				ce - America ck, White, et : White	c.
21215-0036	within 72 hor giene. ier than "nat i, the Medica	Completed	15. Decedent's E (Specify only highest gi Elementary/Seconday (0-12)		(Give i	dent's Usual Occup kind of work done o O NOT use retired)	luring most of work	ing	16b. Kind of B		
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ylan	should be file n and Mental F 7 is marked o raumatic eve	욘	Casimir Wancow	icz			Paul	ine Koz	lowski		
, Maryland	and 2 shou Health and tem 27 is m		19a. Informant's Name/Relationship (i Theresa Swink	Daughter	69	ng Address (Street a			-		ode)
Baltimore,	. Page tment o tant: If jury or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State cerr	netery, cren	sition (Name of natory or other place nislaus C	e) Apri	1 20	20c. Location Baltimo	-	n, State aryland
Bal	permit Depar Impor any in	, ,	21. Signature of Funeral Service Licen	Connelly	22	Name and Address Connelly	ss of Facility Funeral lers Poir	Home Of	Dundal	k, P.	A. 21222
	nysician/ Medical	1000	23a. Part 1. Enter the disease or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Advanc	ed	er the mode of dying	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Examiner	er		b. Due to (or as a consequent b.							
18	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequen						-	
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. Box 68760	Attending Physician: The law requires that the death certificate t redeath. redeath. ector. After this certificate has been signed by the attending physi by the funeral director, page 2 should be detached for use as the t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 Live Birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	eath 3	Ectopic pregnand Other (specify)	у			ate of deliver	y Day Year
ds, P.O.	requires that the consistency of the consigned by should be detained by the consistency of the consistency o	by	Part II. Other significant conditions	contributing to death but not result	ing in the u	nderlying cause giv	ven in Part I.	23e. Did tol	-/		cause of death?
Division of Vital Records,	sician: The law requi certificate has been irector, page 2 should	Completed						24a. Was a autops perfor 1 \(\supersection\) Yes	sy med?/	Were autops prior to comdeath?	sy findings available pletion of cause of
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of V	ig Physter this neral di	te: To	27. Manner of Death	1 Inpatient 2 EF 28a. Date of injury (Month, Day, Year)	R/Outpatier Bb. Time of injury		at	ome 5 Reside 28d. Describe ho			
sion	vttendir death. ctor: Af y the fu	Certificate;	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	n 280 Place of Injury At home		M 1 🗆	Yes 2 □ No	28f. Location (St	met and Numb	or or Rural F	Poute Number
Divi	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral		4 ☐ Homicide determined	building, etc. (Specify)			data and alara	City or Town	n, State)		
	the Hospinin 24 ho	Medical	(Check 2 Medical Examonly one) 3 Certifying Num	vsician: To the best of my knowled niner: On the basis of examination a rea Practioner: To the best of my knowledge.	nd/or invest	tigation, in my opinio	on, death occurred a	t the time, date an	d place, and du	ue to the caus	e(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier	1 14 + 6.0 16.1	2	29c. License			29d. Date signe	ed (Month, De	ay, Year)
	2			Byview Cre	Ba) (Type, F	Print)	07107	,	0		1 2011
	Sta	te	5505 Hopkins 31. Date filed (Month, Day, Year)	Beyview CRC 32. Registrar's Signature	le .	pathn	nove, n	nanylax	d 21	224	
	Registr	ar	ADD 1 0 2011	M M ./	Dark						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 per doc 9915 5-3-11 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Gloria Davis **Alton** 18^{Day} Month 4 2011 ear 12:10 A M **Physician** -04 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Arno1d Future Care Chesapeake If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-22-1926 9. Birthplace (State or Foreign 3irthpiac Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 😾 F 213-22-0965 84 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evant or other traumatic event, the Medical Evant or other traumatic event. 10a State 1 ☐ Yes 2 No Arno1d Director MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21012 USA 305 College Parkway Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: white Specify: ģ 3 XXVidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Architectural Firm Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be Foreman Bertha Irving Davis ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21401 2018 Valley Rd., Annapolis MD Mr David Berger / friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metro Crematory 4/19/2011 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signatur o Funda 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy SE Glen Burnie MD 21061 M01364 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and D nd Death Immediate Cause (Final ears Physician advance disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leafing Limit clark cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine be executed and burial-tra Due to (or as a consequence of): Box 68760 physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnan 3 Ectopic pregnancy in the past 12 month Year 4 Pregnant at time of death 5 Other (specify) P.0. ed by the detached 23e. Did tobacco use contribute to the cause of death? signed by be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ iknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖸 Division of Vital 25. Was case referred edical examiner? director, 26. Place eath (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient this Certification: To funeral Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 27. Mannu atural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (MOTHIN, Day, Day)

4-19-201/

Perint)

Eterars Hwy Millersville MD 21108 296 Signatu d title of certifi ed cause of death (Item 23a) (Type, Print) 30. Nameland address of person Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Amend Item 14 per fh,g914,04/20/2011 dhbeath 12543 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BAKER 4105AM DEBORAH フェアコ 17 PRIL 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARBOR HOSPITAL BALTIMORE NA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MD **Funeral** Days 1 ☐ M 2 🛣 F Director 217-56-9286 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dundalk Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 65 N. Dundalk Avenue 21222 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Caucasion African þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: American 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Berry Plastics 12th Grade Machine Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Hensley Shiflett Margaret Luella Drumm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Alan Baker-Son 7831 Saint Fabian Lane Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimore, MD 4 Donation 5 Other (Specify) 04-15-11 Holly Hills Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Fallure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Kidne Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ng physician and as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cirrhosis alcohol secondary 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed · closmolium difficile 24b. Were autopsy findings available prior to completion of cause of death? colitis 24a. Was an autopsy 1 ☐ Yes 2 ☒ No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier RFS -001 M.D APRIL 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. HAMOVER APTICA 3001 STREET. BALTIMORE MD - 21225 IMIAZ 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ \mathcal{D}_{M} 201 Medical 4a. Facility Name (if not institution, give street and number) b City, Town, or Location of Death 4c. County of Death Examiner m If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, Number Age (In yrs. last birthday, **Funeral** Days 1 M 2 D F Hours Min. Months Director 58-589 Usual Residence of Decedent 28a-f show e 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Examiner must be notified at Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral ers 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ō Completed by Yes 2 LAC Maryland 21215-0036 1 Yes 2 Wo If Yes, Give Year or Dates Specify Blace 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) abore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Important; If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of City or Town, State 20c. Location Date Page 1 a cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) nestown ame and Address of Facilit Signature of Funeral Service Licenses Ronald mala 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Mutiorgan

Due to (or as a conservence of): disease or condition Medical resulting in death) Examiner 5 Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events es a nonsequence of the attending physician and thed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attanding helician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death 2 No after death.

Director: After this certificate has been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv perforn 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMORIAL HOSPITAL, BALTIMORE, MD UNION TI R 2 32. Registrar's Signatur State Registrar

Baltimore, Maryland 21215-0036

Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien

Certificate of Death

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an cal	Decedent's Name (First, Middle, Las Joanna Mae Boyer	•				2. Date of De		Year	3. Time of Death 2:50am _M		
ier	4a. Facility Name (If not institution, give Manor Care- Ruxton	e street and number)		4b. City, Town, or Ruxton	r Location of Death	1	4c. County of Death Baltimore County				
	210 20 1100	ex 7. Age (<i>In yrs.</i>	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da September	Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreig eptember 18 1931 Mary Land				
	Usual Residence of Decedent	40.00	-					T.	(0.1.1.1.1.00.11		
ctor	Maryland Baltimore		y, Town or Loc ddle Rive						10d. Inside City Limits 1 ☐ Yes 2 ☐ X No		
Funeral Director	10e. Street and Number 1900 Grove Manor Dr	ive		10f. Zip Code 21220			10g. Citizen USA	of What Cou	ntry?		
e	11. Marital Status	12. Was Decedent Ever in U	.S. 13. V	Vas Decedent of H Yes, specify Cubi	lispanic Origin? (S	pecify Yes or No	14.	Race - Ameri	can Indian,		
by Fun	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Yes, specify Cuba ☐ Yes 2☐ X No	an, Mexican, Puèrt Specify:	o Rićan, etc.)		Black, White, ec <i>ify:</i> Wh	etc. i te		
Completed	15. Decedent's Ed (Specify only highest gra	l ducation ide completed)	16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	eation during most of wor	rking	16b. Kind o	of Business/Ir	dustry		
윤	Elementary/Secondary (0-12)	College (1-4or 5+)	Book Ke		-/		lizedo	Brothe	rs		
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To Be	17. Father's Name (First, Middle, Last) Carl Meinke				18. Mother's Nan Hazel Hu		, Maiden Sur	name)			
	19a. Informant's Name/Relationship (Patricia Luber (Daug			g Address <i>(Street</i> Gunpowder			ber, City or Town, State, Zip Code) and 21102				
	20a. Method of Disposition 1 🗆 Burial 2 🗶 Cremation 3 🗀	Removal from State	cemetery, cren	sition (Name of natory or other place matory Apr		Date	Baltimore, Maryland				
	4 Donation 5 Other (Specif	′′			i		DOLOL	ioro, i ar	y 201 KI		
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Time Inc 23. Name and Address of Facility Time Inc 7401 Belair Road Baltimore, Maryland 21236										
	23a. Part1. Enter the disease of complications that caused the death on one tenter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End Shock or prespiratory arrest, shock										
_	Sequentially list conditions,	b									
Examiner	Sequentially list conditions, if any, leading to immediate cause. E.ite. Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec									
ical Ex	resulting in deathy East										
an/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Feta		Fotonic pregnanc		23d. Date of delivery		,			
Physicia	In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o		Other (specify)	,		Month Day Ye				
P	Part II. Other significant conditions	contributing to death but not res	sulting in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute to	the cause of death?		
ted by					· · · · ·	1 Yes 2 No 3 Probably 4 Unknown					
E autopsy prior to cor								opsy findings available ompletion of cause of 2 No			
Be (25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only	one)				
examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify)									ifv)		
cation	1 ■ Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	ty Year) Injury Work? M 1 ☐ Yes 2 ☐ No								
Certifi	4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	fy)	eer, ractory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Ph	nysician: To the best of my known of the basis of examinating and manner stated.	owledge, death ation and/or in	n occurred at the ti vestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) an , date and pla	d manner as ace, and due	stated. to the cause(s)		
Me	29b. Signature and title of contifier	100		29c. Licens			29d. Date s	igned (Month	, Day, Year)		
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ļ.	30. Name and address reson who	completed cause of death (Iter	m 23a) (Type,	Print)	wire.	TUWS	UN,	MD	212026		

State Registrar

31. Date filed (Month, Day, APR 2 0 2011

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7505 32. Registrar's Signature Osw

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month -INNOOD Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1**X** M 2 □ F Days (Month, Day, Year) 07 - 16 - 50 NC Director 10-Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 57 marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore XX Yes 2 No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 934 E. Lake 21212 Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian,
Black, White, etc. African 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: American 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 in and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Construction Co. Cement Finisher 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Blount Hazel Johnnv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\,21212$ Beverly Bell-Wife 934 E. Lake Avenue Baltimore, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ayden Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 04-23-11 Ayden, NC 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complications Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown icate has been sig r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy perform death? Stag this certificate 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: ည 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🜠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and fittle of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL STELLA BENESCH 20 IT 8:40 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HARFORD FOREST HILL HEALTH & REHAB CENTER Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 212-14-8501 1 □ M 2 🗓 F Months Days Hours Min. 93 **Director** 02/10/1918 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ner must be notified MD Anne Arundel Glen Burnie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 Crain Highway N, Apt. 867 21061 USA 12. Was Decedent Ever in U.S. "natural", or iten edical Examiner 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ XIo Specify: Completed 3XXWidowed 4 □ Divorced Year or Dates. the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene, I other than " College (1-4 or 5+) Elementary/Seconday (0-12) 12 Social Services State Government Be 18. Mother's Name (First, Middle, Maiden Surname julia Bembene 17. Father's Name (First, Middle, Last) Department of Health and Menta Important: If item 27 is marked any injury or other the ၉ Stanley Zebrowski Bembenek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia C. Bleuel / Daughter 2305 Aquilas Delight, Fallston, MD 21047 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Final Journey crem. 4 ☐ Donation 5 ☐ Other (Specify) 4/18/2011 Woodbine, MD 21. Signature of Funeral Service Licensee Dorrota Marshall 22. Name and Address of Facility
Maryland Cremation Services Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) dureta th Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive heart for Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No certificate ≥ □ No 1 🗌 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 this 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending hours after death.

neral Director: After dilled in by the fun 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral I completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Prectioner: To the boat of my knowledge, each occurred at the time, date and place, and due to the cause(s) and manner stated. 29b, Signature and title of certifier 29c. License number 2332232 april 18, 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ R. Beatty Month Natalie 250PM 2011 4 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Roseda 1 e Ballimore FRANKLIN SQUARE HOSPITal 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth Funeral Min. 1 □ M 2 🕱 F Months Davs Hours (Month, Day,) 212-18-4288 Director MD Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director MD Baltimore ms 23a or 28a-f s must be notified X□ Yes 2 □ No 10g. Citizen of What Country? 10e, Street and Number 10f, Zip Code USA Funeral 40 Glenshanon Court, Apt. G 21221 death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten ledical Examiner r 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. The the 27 is marked other than "natural", or with filem 27 is marked other than "natural", or ury or other traumatic event, the Medical Examiury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 № Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Own Home Homemaker Be ^{17. Father's Name (First, Middle, Last)} William Joseph Miller 18. Mother's Name (First, Middle, Maiden Surname)
Jeanne Sachs ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) w 7420 Nathaniel Dr., Mount Airy, MD 21771 William J. Miller III/Nephew permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final journey crem. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Decremation 3 Removal from State 4/19/2011 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service LicenseeDorota Marshall Ċ 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Preu monia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner FRACTUR Sequentially list conditions, Examine if any, leading to immedicause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury habdom Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy Yes 2 No this certificate 1 Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examine? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 8a. Date of injury Oundri, Day, 28b. Time of **Found:** 12:00 Noon. 28c. Injury at work? 1 ☐ Yes 2 ☑ No 27. Manner of Death 28d. Describe how injury occurred Certificate: s after death. 7 Day, Yea, **72011** 1 🔲 Natural 5 Pendina Probable fall Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 7 2 white Pine RD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined middle River within 24 hours a

To the Funeral C Hom e mod Medical Certifying Physician: To the best of me howledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of xamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractionary of the basis of xamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 34 0550 18/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (1) PR Dacaus R 31. Date filed (Month, Day, Year) Concucy 4000

32. Registrar's Signature R 9000 FRANKLIN SQUAGE OR Balto ind State Registrar

DHMH 17 Rev 7/2009

Physician/ Modical Examiner

> **Funeral** Director

> > Director

Funeral

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Completed

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death with the Maryland

permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If tiera 71 is marked other than "oatural", o'iny or other traumatic event, the Medical Examiner:

Physician

/Medical

≟xaminer

and transi

h certificate be executed

Baltimore. MD 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0654 hrs April 12, 2011 Bart 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital Center Baltimore N/A5. Social Security Number 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) Months Days Hours 530-94-7382 Country)Maryland 1 X M 2 F 38 02/07/1973 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Pas<u>adena</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11th Street 21122 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 4 X Divorced If Yes, Give Year 1994-2000 1 Yes 2 X No specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Construction Company <u>Carpenter</u> 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Christine Koellein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl L. 241 11th Street Pasadena.

20b. Place of Disposition (Name of cemetery, Date Bart (Father) Marvland 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Atlantic Cremation 04/13/2011 Glen Burnie, Maryland Donation 5 Other Specify: 2 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licenses 23a. Py 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval filure. List only one cause on each line. Between Onset and Death a.Peripheral pulmonary thromboemboli complicated by heroin intoxication Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last (X) UNPENDED AMENDED 23a,27,28a-f,per me,g915 5-23-11 sm IF FEMALE 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other | Nursing Home 5 Residence 6 Other 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 X No fd 4-12-11 fd 6:00 am Unknown Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 140 W. West St. Raltimore, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be (Specify) found in rehab facility Homicide 29a. Certifier 1 ____

livision of Vital Records, P.O. Box 68760,	lor Atteoding Physiciao: The law requires that the death certificate be		ficate has been signed by the attending phy-	d in by the funeral director, page 2 should be detached for use as the bun	
ivision of Vital	l or Atteoding Physiciao:	after death.	Director: After this certi	d in by the funeral director	

tending physician a use as the burial -Physician/Medi <u>۾</u> Completed Be Certification: To the Hospital within 24 hours (To the Fuocral completely filled

1 Yes 27 Manner of Death Natural Accident 3 Suicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invest and manner stated.	igation, in my opinion, death occurred at th	e time, date and place, and due to the cause(s)
re and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
$r \cdot \Lambda \qquad \qquad D \cdot \Lambda $	O.C.M.F.	April 13, 2011

				10	
30	Name and	address	of person who co	ompleted cause of	f death (Item 23a)
	Patricia	Aronic	a-Pollak MD.	Assistant	Medical Exa

Assistant Medical Examiner

2. Registrar's Signature

OCME

ORIGINAL

111 Penn Street, Baltimore, MD 21201

State

Registra

11-02699	
Mary Bray	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nary Dray		1- For State Registrar	tate of Maryland		artment o <i>rtificate o</i> :		and	Mental I		Reg. No	2011	12550
Physic Medical Exam		1. Oecedent's Name (First, Midd	T. Bray				-		2. Date of De Month April 8, 2	eath Day		3. Time of Death
		4a. Facility Name (if not instituted 5115 Taft Road						cation of Dea		4	c. County of Death	
Funera		5. Social Security Number	6. Sex 7. Ag	e (In yrs.	last birthday)	Temple If Under	1 Year	If Under 24H	rs. 8. Date of E		Prince George M/DD/YYYY) 9. Bir	thplace (State or
Directo		215-40- 2781	1 M 2 X F	66	Yrs	Months i.	Days	Hours M	in. July	13,	1944 Foreig	untry) MD
, any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	ion						10d. Inside City Limits
Maryland 28a-f show d at once,	ģ	MD Prince	e Georges	Te	mple Hi					10- 0	()M-10	1 Yes 2 No
the Mar a nr 28, tified a	Director	_5115 Taft Rd				10f. Zip Co	ome 0748				tizen of What Cour JSA	ntry?
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 M	12. Was Decedent			s Decedent	of Hispa	nic Origin? (§	Specify Yes or N to Rican, etc.)			can Indian, Black,
after des nl", nr i		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Specify:						Specify:Whit	е			
2 hours "natur"	ted t											
5-0036 Hygiene, Trygiene, To hours after Hygiene, I other than "natural", the Medical Examiner.	ompleted	12		,	Supe	rviso	r			(Grocery S	tore
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Howson	, Last)	Ноое			18.		ne (First, Middle, abeth	, Maidei	n Surname) Draye	r
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ar items 23a nr 28a-f sho rijairy or anther traumatic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relations Jean Hooe	hip(Type, Print) (Sister)		19b. Mailing	Address (Street a	nd Number or	Rural Route Nu	imber, (City or Town, State, MD 2122	, Zip Code) 7
re, M 1 and 2 Health Fitem 2		20a Method of Disposition		20b.	Place of Dienos	ition /Nome	of come		Date		Location - City or	
Baltimore, permit. Pages I as Department of Hee Important: If ite	0	1 Burial 2 Cremation 4 Donation 5 Other Sp	peciry:	Lou					8/11	Ba	ltimore,	Maryland
Ba permi Depar Impo		21. Signature of Funeral Service				ame and Ad		111			Funeral	
Physician /Medical		23a. Part 5 nter the 1 ease, or failure. List only one cause	on each line.							rest, sh	ock, or heart	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Atherosc1 Due to (or as a conse	erot equence o	ic Card	Lovasc	ular	Disea	Ise			Death
	<u>6</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence o	f):							
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Box 68760, death certificate be executed ne attending physician and of for use as the burial - transi	Medical	IF FEMALE:	AMENDED 5 I			4-20-1		23,2/	,g915 5		-11 sm d. Date of delivery	
x 6876 th certificat tending ph	cian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at		2 Fet	al death ner (S <i>pecify</i>)		Ectopic pregn	ancy			ay Year
the death of the attenty the attenty the attentiched for us	Physician/	1 Yes 2 No 9 Unk	ons contributing to death	but not re	0.0			n in Dort I	220 Did t	ahaaaa	use contribute to t	he cause of death?
Records, P.O. I The law requires that the rate has been signed by the page 2 should be detached	ξ		one continuating to death			noenying car	JSG GIVE	mirati.				ably 4 Unknown
cords, aw requinas been a	Completed								24a. Was auto		prior to co	opsy findings available ompletion of cause of
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di this	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier		ER/Outpatient					Reside	ence 6 🗸 Other:	Scene
도 열 급 : 링		27. Manner of Death 1 X Natural 5 Pend	28a. Date of Injui (Month, Day,Ye	y ar)	28b. Time of In		Injury at	t Work? 2 No	28d. Describe	how inj	ury occurred	
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Division To the Hospital or Atter within 24 hours after dear To the Funeral Director completely filled in by th		4 Homicide	mined (Specify) ysician: To the best of my	knowledo	e. death occurr	ed at the tim	e date a	and place, and			nd manner as state	d
Tn the Hos within 24 h Tn the Fun	Medical	one) 2 Medical Exam	niner: On the basis of exam and manner stated.			on, in my opi	nion, de	ath occurred		and pla	ace, and due to the	cause(s)
2014	2	29b. Signature and title of certifier	Usoe				ense nu .C.M.E			1	Date signed <i>(Mon</i> il 9, 2011	tn, Day, Year)
2 pend		30. Name and address of person			'	Ct	D-#:		04004			
St		Margarita Korell MD. 31. Date filed (Month, Day, Year)	Assistant Medical I				, baitii	more, MD	Z 1ZU1			
Regis	trar	VDD 5 U 3U.	11 /Barrel	A.	A 160							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Francis W. Bender 04704/2011 0037a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3230 Miller Ave Middle River Apt 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 🛛 M 2 🗆 F 218-42-6562 67 (Mgnt), P2 (69) 1943 Director Usual Residence of Decedent 23a or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Funeral Director Baltimore Middle River 1 🗆 Yes 2 No MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3230 Miller Ave Apt D 21220 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic 10 Marina injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Bender Margaret Green and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Royte Number, City or Town, State, Zip Code)
412 Elmwood Road Baltimore MD 21206 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau Darlene M. Fox Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Atlantic Crem 04/07/11 Glen Burnie MD 4 Donation 5 Other (Specify) 21. Signat 22. Name and Address of Facility Simplicity Crem & Funeral Service Licensee Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown ils certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 📈 Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 💹 Natural 5 Pending work? 2 🗌 No Accident Investigation after deat Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier . Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SGreene

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year

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CLONE!

Registrar's Signature

11-02755

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 State SHMGANAGE 1662 at the He of Health and Mental Hygiene Robert Arthur Baeder Certificate of Death 1- For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1555 hrs Robert Arthur Baeder April 10, 2011 **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis 603 Admiral Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** reign Country) 488-01-9573 Months Days Hours Min 02/18/1948 MO 63 Director 1 X M 2 F 488-54-8370 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits iny 10b. County 1 Yes 2 No MD Anne Arundel Annapolis or items 23a or 28a-f show must be notified at once. altimore, MD 21215-0036

int. Pages I and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.

ordant: If item 27 is marked other than "natural", or items 23a or 28a-fabo ray or other transmic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 21401 10g. Citizen of What Country? 10e Street and Number 603 Admiral Drive Unit 303 USA 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 4 Divorced If Yes, Give Year 1 967-87 Specify: White 1 Yes 2 X No specify: 3 Widowed ձ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Nuclear Physicist 5 +18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harriet Kathryn Riemann Arthur George Baeder Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ၉ 24 Shireford Lane St Louis MO 63135 Harriet Baeder Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, rematory or other place) 1 Burial 2 X Cremation 3 Removal from State Glen Burnie MD Atlantic Crem 04/15/11 4 Donation 5 Other Specify: injury or 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service Licen-ThomasAllenPA 7090 Ridge RD Hanover MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Medical Retween Onset and failure. List only one cause on each line Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease 1xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Course (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED physician a UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death use as t past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown ō Unknown ţ 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown <u>۾</u> Chronic Alcoholism Completed 24b. Were autopsy findings available 24a Was an certificate has been rector, page 2 should prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2 No 1 🗸 Yes 26. Place of Death (Check only one) After this certification funeral director, 1 25. Was case referred to medical **Division of Vital** Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the fi Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 11, 2011 O.C.M.E. ne 1 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner 31. Date filed (Month, Day, Yea 2. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BORIL 20/1 45 A. M Medical **Examiner** 4b. City, Town, or Location of Death County of Death BAITIMORE ALTIMORE 8. Date of Birth Birthplace (State or Foreign Country) Funeral Min Director Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Tes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral , or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗹 No Specify. 51a "natural" 3 Widowed 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surn, ပ 19a. Informant's Name/Rela nship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 0 ela 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) butus 21. Tre of Funeral Service License Name and Address of Facility 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate rval Betweer Onset and Death Physician MYOCARDIM disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 Line of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 2 No 1 Yes __ Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 4NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Hame 5 ☐ Residence 6 ☐ Other (Specify) 4 hours after death.

**uneral Director: After this ted filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) **Physician** 2 Date of Death 3. Time of Death Medical Examine March 17, 2011 LAVOY COFFEE 0111 hrs ERIC 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death 1276 Route 3 S Crofton Anne Arundel 9. Birthplace (State or Foreign WASHINGTON Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) Months Days Min. Director Hours 579-64-6289 59 APRIL 21 1951 1. 3 M 2. F Country) DC Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No DC WASHINGTON Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1723 D STREET SE 20003 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Married White etc. 1 X Yes 2 NoARMY 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify: Specify: BLACK ፩ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industry event, the Medical Exam Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 AUTO MECHANIC PRIVATE 12TH 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Be CORA FRANCES SPEARMAN COFFEE LYNN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2120 BROOKS DRIVE DISTRICT HGTS, MARYLAND 20747 ERIC COFFEE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) ARLINGTON NATIONAL CEME 5/26/11 ARLINGTON, VIRGINIA 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part I. Enter the disease, or complications that cours of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Hypertensive Cardiovascular Disease Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transi The law requires that the death certificate be executed ician/Medical X UNPENDED AMENDED 23a,27 per me g914 4-22-11 vt Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant et time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed' Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA this 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No hours after death Director: the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Fo the Funeral 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 17, 2011 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

AMEND 28A-F, PER MD 6930 8/8/12 TRT State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 1249 PM (e cil Cornell Creashaw 2011 Medical 4a. Facility Name (if not institution, give street and number)
Howard Couwty GENERAL HEAT Examiner 4b. City, Town, or Location of Death 4c. County of Death COLUMBIA (to WAKE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral 1 M 2 □ F 216-32-7945 76 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the May/land Department of Health and Mertal Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1-10WARO MD 1 Yes 2 No 10g. Citizen of What Country TRICROSS DR Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) (FハノEハリ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2113 6 625 MIIO Baltimore, 20b. Place of Disposition (Name of tun k cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fundal Service Licensee 22. Name and Address of Facility Howell 10220 Guil Fond Rd, JE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final there stiol Physician/ intentiona caustic acid disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine it any, leading to immedia cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for sels consequence on and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

A Prednant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury 1
Natural 5 Pending 1 ☐ Yes 2 【XNo SUBJECT DRANK BATTERY ACID 2 ☐ Accident 3 ☑ Suicide 4/1/2011 Investigation UNK Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Boute Number City or Town, State) **629 TRICCROSS DR** 4 Homicide determined COLUMBIA, MD HOME Medical 29a. Certifier 1 🛒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month. Day, Year) 20066 JII 2011 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kawa 31. Date filed (Month, Day, Year) 2. Registrar's Signature 2 U 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Looper Tyronp 9:00A APRIL Medical 7011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4700 Sipple Avenue Baltimore If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours 1 X M 2 □ F **Director** 220-72-5391 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1X Yes 2 ☐ No MD n/sBaltimore 10e. Street and Number 10f. Zip Code o 10g. Citizen of What Country? If item 27 is marked other than "natural", or items 23a o or other traumatic event, the Medical Examiner must be Completed by Funeral 4700 Sipple Avenue Page 1 and 2 should be filed within 72 hours after death went of Health and Mentai Hygiene. ant: If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔯 No Specify: Specify: African-American 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maryland Transportation 12th Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Benjamin Cooper Evelyn Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4010 Mortimer Avenue, Apt. 2, Baltimore, MD 21215 Jacqueline Cooper/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite any injury or oth Date Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) cemetery, crematory or other place) Woodlawn Cemetery 4-21-2011 Woodlawn, MD Signature of Funeral Service License 22. Name and Address of Facility Wlie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death rung cancer Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 g Unknown been signed by the s should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law r
 24 hours after death.
 Funeral Director: After this certificate has b autopsy performed? funeral director, page 2 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner?

1 \(\text{Yes} \quad 2 \text{ No} \text{No} \) 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\overline{\psi}\) Residence 6 \(\sum \) Other (Specify) ည ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending ☐ Accident☐ Suicide Investigation ompleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the F only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) VS/Kaj apriline M.D 4/15/11

Registrar

State

GLEN Burnie

32. Registrar's Signature

- Mb .

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matrin BIVD

31. Date filed (Month, Day, Year)

11-02824

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hristopher Covi	•	on State of Maryland / Departm 1-For State Certific Registrar			ental Hyg	-	2011	12557	
Physicia Medical Exami	in/	1. Decedent's Name (First, Middle,Last) CHRISTOPHER COVINGTON			- 1	. Date of Death	Dav Year	3. Time of Death 0650 hrs	
		4a. Facility Name (if not institution, give street and number) Northwest Hospital	4	b. City, Town, or Locati Randallstown	on of Death		4c. County of Death Baltimore Cou		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 214–15–7946 1 X M 2 F 34	rthday) Yrs.		ours Min.	8. Date of Birth 03/04/1 03/06/			
daryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent 10a. State 10b. County MD 10c. City, Town BALTI 10e. Street and Number				1400	;. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No	
th the Maryland 23a or 28a-f sho notified at once	I Director	6603 ALTER		10f. Zip Code 21215	21207	109	USA	iu y ?	
r death wi	/ Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	If Ye	s Decedent of Hispanic es, specify Cuban, Mexic	can, Puerto Ri		White, etc.	ican Indian, Black,	
10re, MD 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. t: If item 27 is marked niter than "natural", pr items 23a or 28a-f shouther traumatic event, the Medical Examiner must be notified at once	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)						b. Kind of Business/Industry	
ID 21215-0036 should be filed within 7 and Mental Hygiene. T is marked other than natic event, the Medica	Be Com	17. Father's Name (First, Middle, Last) ROBERT COVINGTON, SR.	ANAGE			irst, Middle, Ma	HOME DEPO' diden Surname) THOMAS	<u> </u>	
두 달 등 등 등		GWENDOLYN THOMAS/MOTHER	ϵ	Address (Street and N	BALTIN	ORE, MI	21215		
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traum		1 X Burial 2 Cremation 3 Removal from State St. crest 4 Donation 5 Other Specify:	MEM-	PARK	04/2	1/2011	BALTIMORE	, MD	
Physician		21. Signature of Funeral Service Licensee 23. Part I. Enter the disease, or complications that caused the death. Do n	E	BALTIMORE, 1	MD 2121	L7		NS F.H., IN	
/Medical Examiner		failure. List only one cause on each line: Immediate Cause (Final disease or condition resulting in death) a. Complications of Due to (or as a consequence of):	Chro	onic Alcoho	l Abuse	2		Between Onset and Death	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last							
be executed ician and urial - transit	dical Exa	events resulting in death) Last Due to (or as a consequence of): d. X AMENDED # 23a,27,g9 # 20b,perFH.	15, 5-	18-11 sm	110 HOC 1	O.S. Davis	TNE 001/	//20/2011 III	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	₽Ì	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy	/ 2 Fet		ppic pregnanc		23d. Date of delivery		
ds, P.O. equires that the signed by to uld be detached.	全	Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying cause given in	Part I.		2 No 3 Prot		
of Vital Records, ag Physician: The law require there this certificate has been sineral director, page 2 should be	Completed	25. Was case referred to medical		26.Place of Dea	oth (Chook onl	autopsy perform 1 Yes 2	prior to death?	completion of cause of	
on of Vital ending Physicial auth. or: After this cer	ition: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/C 27. Manner of Death 1 Natural 5 Pending Pending Hospital: 1 Inpatient 2 FR/C 28a. Date of Injury (Month, Day, Year)	Outpatient Time of In	3 DOA Other	Nursing Fork? 28	Home 5 R	esidence 6 Other	:	
Division pital or Attendir ours after death. eral Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, f	farm, stree	t, factory, office building	, etc. 28	Bf. Location (Str or Town, Sta		ral Route Number, City	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or and manner stated.		on, in my opinion, death	occurred at the	ne time, date an	nd place, and due to th	e cause(s)	
le al	2	29b. Signature and title of certifier 30. Name and address of person who completed cau e of death (Item 2.a)		O.C.M.E.	per	1	29d. Date signed <i>(Moi</i> April 14, 2011	nth, Day, Year)	
Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	11 Penr	n Street, Baltimore	, MD 2120	01			
Regist	_	APR 2 0 2011 Januar S. S.	RIGINAL			<u> </u>	OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Frances Ethel Carroll Medical 4a. Facility Name (if not institution, give street and n. Examiner 4b. City, Town, or Location of Death 4c. County of Death POLCEN CONTEN ANNE DULNUE Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 17, Birthplace (State or Foreign Country)
 MD . Age (In vrs. last birthdav **Funeral** Months Days Min. 1 M 2 KX 72 217-38-0641 **Director** 1938 Usual Residence of Decedent 28a-f show 10b. County notified at 10a State 10c. City. Town or Location 10d. Inside City Limits Director Glen Burnie MD Anne Arundel 1 Yes XX No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 21060 621 New Jersey Ave SE USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify "natural", Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **US Postal Service** Clerk and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ pe Emma Szalae Gilbert G. Dulaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Important: If item 27 any injury or other tra 20 Balset Ct., Windsor Mill, MD 21244 Courtney D. Britton Grandaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₽ 1 Burial 2 Excremation 3 Removal from State Apr 19, 2011 Baltimore, MD Bayview Crematory 4 Donation 5 Other (Specify re of Funeral Service Li Gregory Fink 22. Yame and Address of Familia, P.A. M01148 426 Crain Hwy S., Glen Burnie, MD 21061 Part 1. Enter the di shock, or heart ail nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LORONARY disease or condition Medical resulting in death) Due to (or as a consequent e of) Examiner Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed and burial-tran to (or as a consequence of) resulting in death) Last attending physician Physician/Medical HOLESTEROL Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 ☑ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 1 🗌 Yes 2 🗆 No Yes 25. Was case referred to medical mpleted filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 🗖 No Other: 10 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify hours after death. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to only one 3 [the cause(s) and manner as stated 29b. Signature ditle of certifier 04-16-2011 mpleted cause of death (Item 23a) (Type, Print) RICHARD & 530

W DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

State Registrar

Medical

completely

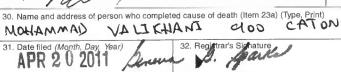
within 2

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certific



and manner stated

29c. License number

AVE

D0069177

29d. Date signed (Month, Day, Year)

MD

2011

21229

APRIL

BAITIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-02872 State of Maryland / Department of Health and Mental Hygiene Henry Cogdell Certificate of Death 1- For State Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 1521 hrs April 15, 2011 Medical Examiner Henry Cogdell Henry Edwin Cogdell 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Harbor Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min Months Director MD Mar 2, 1952 218-60-3714 1 xxM 2 F 59 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 XX No 28a-f show Glen Burnie Anne Arundel t. Pages I and 2 should be filed within 72 hours after death with the Maryland trinent of Health and Mental Hygene transit. If item 27 is marked other than "matural", or items 23a or 23a-f abo y or other transmattic event, the Medical Examiner must be notified at once. irector 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21060 # 104 6700 Rapid Water Way 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 XX Married 1XX Yes Black. Yes, Give Year Specify 1 Yes 2 xx No specify: 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 **US Navy** Chief Petty Officer 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Corine Cooley Henry J. Cogdell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6700 Rapid Water Way # 104, Glen Burnie, MD 21060 Jean Cogdell 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 XXCremation 3 Removal from State Apr 22, 2011 Crownsville, MD Crownsville Veterans Cem 4 Donation 5 Other Specify: 22. Name and Address of Facility Fink Funeral Home, P.A. 21. Signature of Funeral Service Licensee 426 Crain Hwy S., Glen Burnie, MD 21061 K. Gregory Fink M01148 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death a Intraoral Gunshot Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and 1 per me g915 5-11-11 vt Physician/Medical UNPENDED X AMENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year 1 Live birth Fetal death 3 Ectopic pregnancy Month 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has be rector, page 2 sh performed? death? 1 🗸 Yes 2 No ✓ Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes ဥ 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury After 27. Manner of Death Subject shot self Apr 15, 2011 1437 hrs 1 Natural 1 Yes 2 V No Pending Investigation 2 ___ Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide 6 Could not be or Town, State) 7600 Rapid Water Way Apt 104, Glen Burnie, MD determined (Specify) Multi-Family Apt. To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wildedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier April 16, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD.

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OGME

32. Registrar's Signature

31. Date filed (Month, Day, Year)

ORIGINAL

			For	State of M	faryland / De				-	_	ible.	
			State Registrar		-	Certificate			, ,	g. N2 0		12561
	Physicia Medic		Decedent's Name (First, Middle, La	Mary Ion	a Dawson				Date of Death	15 2	O II	3. Time of Death
	Examin	er	4a. Facility Name (if not institution, giv BAGMORE WASH		EDILAL C	4b. City, 1	own, or Location		LRNIE	4c. County	_	ARunoEL
	Funeral Director		5. Social Security Number 6. S	Sex 7. Ag	ge <i>(In yrs. last birthd</i> 73 Yr	Months	1 Year If Und Days Hours	der 24 Hrs. 8	Date of Birth (Month, Day,)			place (State or Foreign try)land
/land	f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o						1	0d. Inside City Limits
he Mary	or 28a-	Direc	Maryland Balti 10e. Street and Number	imore	Balt	imore	Code		10	ng. Citizen of V	Vhat Cour	1 Yes 2 X No
h with ti	nust be	Funeral Director	2 Nunnery Lane				21228			U.S		.,,
036 rs after deat	ıral", or iten Examiner ו	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		13. Was Decede If Yes, speci 1 Yes 2	ent of Hispanic of Cuban, Mexic fy Cuban, Mexic		y Yes or No- an, etc.)		e - Americ k, White, e Wh	
21215-0036 within 72 hours after death with the Maryland	ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12) 11th		5+) (C	ecedent's Usual Bive kind of work e. DO NOT use Homemake	done during m retired)	nost of working	1	6b. Kind of Bu	usiness Inc	
	dental Hyg arked othe ttic event,	To Be	17. Father's Name (First, Middle, Last)	Sothoron	F. Thomps	son	18. Mo		rirst, Middle, Ma n Suit	aiden Surname	y	
Maryl d 2 should 1	alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Louis Thompson			Mailing Address			-			Code) 1and 21225
altimore,	nt; If item ry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State		isposition (Name crematory or other		Dat 04/19		Oc. Location - Glen B		wn, State e, Maryland
Balti. Permit. F	Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic even once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 2.									
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	nplications that cause one cause on each lin	d the death. Do not ne.	enter the mode	of dying, such	as cardiac or re	espiratory arres	t,		Approximate Interval Between Onset and Death
	ysician/ Medical xaminer		disease or condition resulting in death)	a. Due to (or as	a consequence of):	5		2.	- 0		-	Silost and Boam
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. OAST	a consequence on.	STINE) (SLE	21).			
be executed	/sician and e burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						-	
	siciar buria	cal	·	■ d							\perp	
Division of Vital Records, P.O. Box 6876	signed by the attending phy d be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death at time of death	3				23d. Dat	te of delive	ery Day Year
S, P.O	signed by	<u>ا ۾</u>	Part II. Other significant conditions	contributing to death	but not resulting in t	he underlying ca	ause given in Pa	art I.				ne cause of death?
ecord e law requ	ge 2 shou	Completed							24a. Was an autopsy perform	ed?	prior to cor death?	osy findings available mpletion of cause of
an: Th	rtificate tor, pag		25. Was case referred to medical				26. Place of D	eath (Check or	1 🗆 Yes 2	■ No 1	Yes	2 No
f Vit	this cer al direc	욘	examiner? 1 Yes 2 No		ient 2 ER/Outp				5 🗆 Residen			
on of	eath. or: After t he funera	Certificate:	27. Manne of Death 1 Natural 5 Pending 2 Accident Investigation		ury 28b. Tim ay, Year) inju		c. Injury at work? 1 Yes 2		d. Describe how	injury occurre	łd.	
Divisi	within 24 hours after death. To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I		3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	building, et	jury - At home, farm c. (Specify)				City or Town,	State)		Route Number,
dsoH ev	in 24 hou he Funer ipleted fil	Medical	(Check 2 L Medical Exam	ysician: To the best of niner: On the basis of e rse Practioner: To the	examination and/or ir	ivestigation, in m	y opinion, death	occurred at the	e time, date and	place, and due	to the cau	use(s) and manner stated.
P _t	To t		29b. Signature and the of certifier	540	mi	>	License numbe	5149	? (d. Date signed	(Month, E	2011
5			30. Name and address of person who	completed cause of c	death (Item 23a) (Typ	pe Print)	NIVE	Cle.	n Bus	ne	MI	20161
	State Registra	8	31. Date 1 1 1 1 1 1 2 1 1 1 2 1 1	Server 32. Registr	s Signature	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ronald Warren Diamond Sr Month 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospita Kosedale auare yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD Funeral 5. Social Security Number 219-52-2943 Date of Birth 1950 Sex ↑□M2□F Days Hours Min. Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 USA 3721 White Pine Rd Apt F 12. Was Decedent Ever in U.S. Armed Force Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. White Rmald ö Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Street Sweeper Public Works Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Woodrow Diamond Margaret Weese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3721 White Pine Rd Apt F Baltimore MD Debra Diamond Wife 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Atlantic Crem 04/12/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv of Juneral Service Licen ThomasAllenPA 7090 Ridge RD Hanover MD nome 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician therosclerotic Cardiovasci lar disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of): by the attending physician and stached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 2 🗆 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 💌 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D0056092 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 ranklin Simare State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 30 sma Medical 4a. Facility Name (if not institution give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NA TTOSK ose alcho If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 215-34-7693 Days Months Min (Month, Day, Year) 1 0 M 2 - F Director 111 ar Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director or 28a-f sl notified NA 1 Xes 2 No 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? must be 23a Funeral une ıral", or items 1 I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimole, Maryland 21215-0036 1 🗆 Yes 2 🗷 🕦 "natural", 3 Widowed 4 Divorced Completed Year or Dates item 27 is marked other than "natu other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Adver Elementary/Seconday (0-12) Diater Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Mental မ Page 1 and 2 should be rore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tieno Hawthou 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of 1 Burial 2 Cremation 3 Removal from State Important: If any injury or once. -23 4 ☐ Doyletion 5 ☐ Other (Specify) wre of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heartfailure. List only one cause on each line.

ediate Cause (Final Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical sequence Due to (or as a co **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached! 9 Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de Completed by Division of Vital Records, 2 \square No 3 Probably 4 Unknown 246. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Hospital or Attending Physician: The 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner Other: 4 Nursing Home 5 Residence 2 No ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation
6 Could not be determined Accident 24 hours after deat Funeral Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the 29d. Date State Registrar

DHMH 17 Rev 7/2009

State Registrar Certificate of Death L. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 1 9 Day Juanita English 5:40 A M 04 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Care Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Carolina Months Days Hours Min 215-66-2092 1 M 2 X 57 08/08/1953 **Director** Usual Residence of Decedent or 28a-f show 10a. State 10h County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits rector MD Baltimore 1X Yes 2 No õ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2611 Cecil Avenue 21218 USA buld be filed within 72 hours after death v d Mental Hygiene. marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ※ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Black Specify: Completed 3 XWidowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Clara Cromartie Gid Brackett and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Troy Brackett (Son) 2611 Cecil Avenue, Baltimore, MD 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 4/2//2011 Baltimore, MD

Wanglin C. Greene Funeral Services

4905 York Road Baltimore

A Work Ford F.S.

2431 E. Oliver St., Baltimore MD 2126

enter the mode of dying, such as accommon and services and such as accommon and services. 20c. Location - City or Town, State Date cemetery, crematory or other place)
t. Stanislaus 1 Durial 2 Cremation 3 Removal from State St. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Juneral Service Licentes pears perDVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition MCBJ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes No Day Year Pregnant at time of death led by the a detached f 9 Unknown 9 | Unknown Records, P.O. been signed by should be deta Part II. Other significant conditions contributing death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an as e 2 autopsy page certificate 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 No 읻 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending work' М 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. nly one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of certifier Signature 4/19/11 20071287 Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Suite 4105, Baltimore, MD 21204 31. Date filed (Month, Day, Year) State APR 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Easton :36 homas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 15 move a 1105 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex. 1 M 2 D F cial Security Number Funeral Months Hours Min UNK MD Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director MDBaltimore Dundalk Examiner must be notified 1 🗌 Yes 2 🔀 No 10g. Citizen of What Country? ö 10e. Street and Number 10f. Zip Code 21222 Funeral 8204 North View Rd 23a USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. ö δ 1 Never Married 2 Married 1 ☐ Yes 2 H No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Specify: White 3 Widowed 4 Divorced "natural" Completed of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction General Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Gorman Jesse Lee Easton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8204 North View Rd Dundalk MD 21222 t of Health Brother James Easton 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ö Atlantic Crem 04/13/11 Glen Burnie MD Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ respirator disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner neum Onia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician stached for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 🗌 Unknown P.0. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy ☐ Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 1 Yes 2 No Investigation 2 Accident 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by determined building, etc. (Specify) City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature apartitle of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

Russell Alexander MD.

APR 20 201

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

ULINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylan	d / Department of I		Mental Hygi	ene	12567
			Registrar 1. Decedent's Name (First, Middle, Last))	Certificate of I	Death	2. Date of Death	eg. No. U	12301
н	Physicia			cks			Month A A	Day Year	3. Time of Death
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			Northwest Hosp 5. Social Security Number 6/Sex	7 . 7		day Stown	Lobertein	Bal.	timore
	Funeral Director				35 Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign cuntry) Maryland
	d it	_	Usual Residence of Decedent 10a. State 10b. County	100 Cit	y, Town or Location		l octiv	/	1404 1444 07 1444
	Maryland 28a-f show otified at	ecto	Maryland NI	A loc. Git	Box	timore			10d. Inside City Limits 1 Yes 2 No
	the Manager	ä	10e. Street and Number		10f. Zip Code	timore 21215	10	0g. Citizen of What Co	ountry?
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	6617 Eberle					US;	4
(0	or iter	by Fu	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
5-0036	ural", ural", I Exar	ted b	3 🗌 Widowed 4 🔲 Divorced	If Yes, Give Year or Dates.	1 🗆 Yes 2 🖫 No	Specify:		Specify: 131	ack
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Maryland	should be file n and Mental h is marked o raumatic eve	-	William Artes 19a. Informant's Name/Relationship (Type	China	T	Nata	ie Hicks	<u> </u>	2121
			Natalie Johnson	-mother	19b. Mailing Address (Street	and Number or Run te Driv	al Route Number, C	city or Town, State, Zij 101 – Balt	imar Ma
Baltimore,	0 4 - 1		20a. Method of Disposition 1 Burial 2 Cremation 3 I		Place of Disposition (Name of semetery, crematory or other place	ce) !	Date 2	20c. Location - City or	Town, State
tim	t. Pag tmen tant: ijury		4 Donation 5 Other (Specify)	M	etro Crimatery		19/11	atonsville	Maryland
Bal	permir Depar Impor any ir		21. Signature of Funeral Service License	Parker	22. Name and Addre	enick A	Kerfun ve. Bot	timore M	aryland aryland
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Box 6	hat the death certific ed by the attending i detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d	ıl death 3 🗌 Ectopic pregnand	су		23d. Date of de Month	livery Day Year
B.	he des	hysic	1 Yes 2 No 9 Unknown	g Unknown	death 5 Other (specify) _				
P.O.	s that t gned b	by	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the underlying cause gi	ven in Part I.		acco use contribute to	
rds,	v requires the been signer should be a	eted					1 🗆 Yes	s 2 🖺 No 3 🗆 P	robably 4 🗆 Unknown
eco	has b	Completed					24a. Was an autopsy perform	prior to	topsy findings available completion of cause of
E.	ician: The law certificate has rector, page 2		25. Was case referred to medical		26. Pl	ace of Death (Chec	1	□ No 1 □ Yes	2 <u>U</u> No
Vita	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1	ER/Outpatient 3 DOA Oth			nce 6 Other (Spec	aniant nospice
Division of Vital Records,	ling Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury 28c. Injury work	y at	28d. Describe how		
sion	Attendir r death. cctor: Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho	M 1 □ me, farm, street, factory, office	Yes 2 □ No	28f. Location (Stre	eet and Number or Ru	ral Route Number.
Divi	tal or A rs after al Direct ed in by		4 - Hornicide determined	building, etc. (Specify,)		City or Town,		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attendent. Verton 24 hours attendent. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Examination	er: On the basis of examination	edge, death occured at the time n and/or investigation, in my opinion	on, death occurred a	the time, date and	place, and due to the	cause(s) and manner stated.
	To th e within 2 To the сотре	Σ	29b. Signature and title of certifier		knowledge, death occurred at the 29c. License	number	29	d. Date signed (Month	n, Day, Year)
			> 715 Egjapatrsen			D0057		4/19/	
-	1		30. Name and address of person who co	mpleted cause of death (Item -0 2835 50	23a) (Type, Print) nith Av. S-Zi	3 Ba	Itimore,	MD -217	209
	Stat Registra		31. Date filed (Month, Day, Year) APR 2. 0. 2011	32. Registrar's Signat	ure				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Ruth Hall 1:251 2011 Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3145 E. Nøbles Mill Road Darlington Harford ocial Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year)
Dec 19,1914 **Funeral** 9. Birthplace (State or Foreign 007.07.6509 1 M 2 96 Months Director Maine Usual Residence of Decedent show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified a sury injury or other traumatic event, the Medical Examiner must be notified a 10c. City, Town or Location 10d, Inside City Limits Director MD Harford Darlington 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1839 Trappe Church Road 21034 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces? Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ray Purinton Lila Garland 9a. Informant's Name/Relationship (Type, Print) Rebecca Gardner/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3145 E. Nobles Mill Rd., Darlington, MD 21034 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State chesapeake Crem. 04.20.11 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility cafa/Stephen D. Lohrmann, PA8717 <u> Green Pastures Dr., Balto., MD 21286</u> 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATherosck rotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a nonsequence of) Examin Cause (Disease or linjury that initiated events and -trar resulting in death) Last Due to (or as a consequence of): attending physician if or use as the burial. Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death the Unknown 9 Unknown been signed by should be detac Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 s autopsy death? certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🗹 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Investigation
6 Could not be 1 ☐ Yes 2 ☐ No 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MsRajapameM.D 10057465 4/18/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Glen Burnie, MD. 6934 Ariation BIVD N.S. Rajapakse, MID. 32. Registrar's agnatu State

Registrar

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- 1	- 1	-UZ/4/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For State Certificate of Death			g. No.		
,		Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Ye	ear	3. Time of Death 0820 hrs
edical Examiner		THEODORE ROUSEVELT HOBDAY	tion of Dooth	April 10, 20	011 4c. County	of Dooth	0820 H/S
1		451 Watty Court Baltimore					
Funeral			Under 24Hrs.	8. Date of Birth	(MM/DD/YYY	YY) 9. Birth Foreign	nplace (State or
Director		215-38-9004 1X M 2 F 73 Yrs. World Bays	Iodis Iviii.	12/04	/1937		ntry) MD
<u>k</u>		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
W any		MD BALTIMORE				ļ	1 YXYYes 2 No
daryland 28a-f show 1 at once,	tor	10e. Street and Number 10f. Zip Code		140	g. Citizen of V	Alle et Course	***
or 28s	Director	451 WATTY COURT		10	_		шуг
ith th		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic	Origin2 / Sno	cifu Vos or No	US.		an Indian, Black,
15-UU36 filed within 72 hours after death with the Maryland Hygene. ed other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once,	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexi				ite, etc.	arr iriurari, biack,
rer de		1 X Yes 2 No 3 Widowed 4 Y Divorced If Yes, Give Year 1 Yes 2 X No spec	ecify:		Specify.	: RI	LACK
5-UUS6 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (G	Give kind of wo		16b. Kind of E		
72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO N	NOT use retire	d)			
ZIZIOUOO uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	ם	5 MAIL SORTER			POS	T OFF	TCF
Hygic Tothe		17. Father's Name (First, Middle, Last) 18.Mol	other's Name (I	First, Middle, M			
1 8 B 4 5	Be	THEODORE LEWIS	MYRTLE	WRI			
0 0 0 5	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and I PATRICIA HOBDAY/DAUGHTER 12250 GREEN ME					
l and 2 shou Health and l fitem 27 is		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery		Date	20c. Location		
permit. Pages I and 2 sh Department of Health an Important: If item 27 i		1 Burial 2 ACremation 3 Removal from State crematory or other place)	´`		200. Loodilor	1 - Oily Oil 1	own, dialo
Pag ment tant:		4 Donation 5 Other Specify: METRO CREMATORY		3-2011	BALT	TIMOR	E, MD
ermit Depart mpor njury		21. Signature of Funeral Service Licensee 22. Name and Address of Fac	acility JAME				S F.H., INC
- HH.3	_ 1	1701-31 LAURI	FNC CT	RAT.T	IMORE.	MD '	21217
1		23a Part I Enter the disease or complications that caused the death. Do not enter the mode of dving such s			t shock or h	eart	Approximate Interval
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line.			st, shock, or h	eart	Approximate Interval Between Onset and
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 11:30 PM ELLA MAE JOHNSON APRTI 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) 1 ☐ M 2X F Director 219-16-0461 WASHINGTON.DC 3 1926 Usual Residence of Deceden 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No MD PRINCE GEORGE'S UPPER MARLBORO 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 306 RIDGELY COURT 20774 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. ð Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N College (1-4 or 5+) PRIVATE 6TH BAKERY ASSISTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HENRIETTA GREENE WILLIAM ROBERT BELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2074719a. Informant's Name/Relationship (Type, Print) 7221 LANSDALE STREET DISTRICT HEIGHTS, MARYLAND WILLIAM R. JOHNSON/SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4/16/2011 CLINTON, MARYLAND 4 Donation 5 Other (Specify) RESURRECTION CEME. 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit signed by the attending physician and dbe detached for use as the burial-tran Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 🛕 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident injury 5 Pending a nospinate no 24 hours after death.

ne Funeral Director: After a by the funeral or the funeral work?
1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 🌠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 To the F only one) 29d. Date signed (Month, Day, Year)
April 8, 2011 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3415 HAMILTON ST HYAHDVILLE, MD 20782

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

APR 20

Registrar's Sign

11-02554	
Danielle Jones	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

anielle Jones	4	State of Maryland / Department of Health and Me -For State Certificate of Death	ental Hy	giene	2011	12571
		tegistrar 1. Decedent's Name (First, Middle, Last)	2	Reg. 2. Date of Death		3. Time of Death
Medical Examin	er	Danielle Leigh Jones		April 3, 201		1353 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 2078 Druid Park Drive Apt. 3 Baltimore				imore
Funeral Director		5. Social Security Number 220-94-7647 6. Sex 1 Age (In yrs. last birthday) 32 Yrs. If Under 1 Year If Under 1		8. Date of Birth	(MM/DD/YYYY) 9. Bi 7 / 1 9 7 8 Fore C	rthplace (State or ign MD ountry)
ith the Maryland 23a or 28a-f show any motified at once.	٥	Usual Residence of Decedent 10a. State MD Baltimore Baltimore 10c. City, Town or Location Baltimore 10c. Street and Number 10f. Zip Code 2078 Druid Park Drive Apt 3 21211		10g	. Citizen of What Cot USA	10d. Inside City Limits 1 X Yes 2 No untry?
s after death wi	by Funeral	11. Marital Status 1	an, Puerto R	Rican, etc.) ork done		
7	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Food Service	ce	First, Middle, Ma	Fast F	ood
21215-0036 Muld be filed within 7 Mental Hygiene Revent, the Medica	Be	Francis Xavier Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Ni	Don	na Kaye	e Reed	e, Zip Code)
e, MD and 2 sho lealth and item 27 is	-	Karen Leigh Reed Grandmother 2078 Druid 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Atlantic Crem		Date	Apt3 Ba 20c. Location - City of Glen Bu	r Town, State
Baltimore, permit. Pages 1 a Department of He Important: If the injury or other to		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Thomas Allen F	PA 70	90 Rid	ge Rd Ha	nover MD
Physician /Medical =xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			t, shock, or heart	Approximate Interval Between Onset and Death
ted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of): d.				
e be executed ysician and burial - transit	edical	✓ AMENDED 23a,27,28a-f,per me,g915 5	-18-11	l sm	23d. Date of delive	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buin	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ✔ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ecto 4 ☐ Pregnant at time of death 5 ☐ Other (Specify) 9 ☐ Unknown	opic pregnan	ncy	Month Month	Day Year
P.O. I res that the signed by the be detached	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I.	23e. Did toba		o the cause of death? obably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be in the funeral director.	Completed	25 Was case referred to medical 26.Place of Dea	ath (Check or	24a. Was an autopsy perform	prior to death?	
Vital hysician: r this certi	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	Nursing	Home 5 R	esidence 6 🗹 Oth	er: Scene
ion of tending Pleath. tor: After the funera	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work 1 Yes 2	X No	Unknown		
Division of To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After recompletely filled in by the funeral	Certification:	3 Suicide 4 Homicide 6 Could not be determined Could not be determined Could not be determined (Specify) Residence]	or Town, Sta Baltimor	te) 20/8 Druid re, Md.	Rural Route Number, City Park Dr. Apt 3
o the Hos ithin 24 h o the Fun	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	d place, and on occurred at	due to the cause(the time, date ar	(s) and manner as stand place, and due to	ated. the cause(s)
H × F ×	ž	29b. Signature and title of certifier 29c. License numb O.C.M.E.			29d. Date signed (M April 4, 2011	lonth, Day, Year)
Lord	ŀ	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, E	Baltimore	, MD 21201		
Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. - 1 State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2011 ear Robert Benjamin Jarrett 17 1932 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 X M 2 - F 211**-**16-7115 Yrs 2^Mº1th, 1³9 2°8′ **Director** PA Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Tes 2 No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be r Funeral 104 Welham Ave. NW 21061 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XXNo Specify white Completed 3 X Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Westinghouse Electrical Engineer Page 1 and 2 should be filed witi ment of Health and Mental Hygier ant: If item 27 is marked other I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 27 is marked r traumatic e Herbert Britian Jarrett Natalie B. Fluck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Hood / Daughter 8160 Telegraph Road Severn MD 21144 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State Loudon Park Cemetery 4/22/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ + Cer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No be detached signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dei Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an ours after death.

eral Director: After this certificate has I filled in by the funeral director, page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 XNo 1 Yes Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier соmpleted (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GlenBurnie MD21061 hway. Sint 800; DHAR 32. Figistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 11:53pm Medical 4a. Facility Name (if not institution, give street and num 4c. County of Peath 4b. City, Town, or Location of Death **Examiner** -av altimore 8. Date of Birth
(Month, Day, Year) Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) If Under 1 9. Birthplace (State or Foreign **Funeral** 1 M 2 🗆 F Months Country) 66Yrs. Director June Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County oortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director NA 1 Yes 2 No TIMON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give and Mental Hygiene. Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) trmove(Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To VINZar 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State altimore 4 Donation 5 Other (Specify) Si au re of Funeral Service Licens 22. Name and Address of Facility MOD 5 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequ **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a con attending physician and for use as the burial-transit Due to (or as a consequence resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has autonsy 1 Yes 2 🗌 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28c. Injury at work? 1 □ Yes 28b. Time of 28d. Describe how injury occurred Natural iniury 5 Pending Accident
Suicide 2 🗀 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one title of cer 29b. Signature 29c. License number 29d. Date sigred (Month. Day, Year) D0066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Kofi

31. Date filed (Month,

Owusu-Antwi

827 Linden Ave

Baltimore, MD 21201

General Hospital

32. Registrar's Stanature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Degedent's Name (First, Middle, Last) 2. Date of Death Physician/ A Month Medical Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** tills NursiNG HOME 2007 DY . Sex 1 M M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ifew 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 🛣 No JEOTGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MINO Koreo 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. SIAN 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life: DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1/2/2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Merhod of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other) 4 Donation 5 Other (Specify) Signature of Funeral Service Deensee 22. Name and Address of Facility gar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) DNG Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to for an a compague, or of: To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed ANEMIA that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 욘 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at (work? 1 ☐ Yes 2 ☐ No Medical Certificate: Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of sertifier 29c. License numbe 29d. Date signed (Month, Day, Year) D30132 ess of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygien for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Deatl 3. Time of Death Physician/ Month ANLE ROKUS 833 AM Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SLEN ISWAME DALTIMORE WASHNUTEN/ PLDICALLER MUDEZ Social Security Numbe 8. Date of Birth (Month, Day, Year) Nov. 21, 1944 7. Age (In vrs. last birthday Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Hours Maryland Director 216-42-6913 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at rector 1 🗆 Yes 2 🗓 No Maryland Pasadena Anne Arundel ö 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 151 Lakeshore Drive 21122 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 X Married <u>Ş</u> Maryland 21215-0036 1 Yes 2 X No Specify. "natural", Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) N/ASteamship Trade Assoc <u>Longshoreman</u> traumatic event, æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မှ John Krokos, Sr. Beatrice Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trat Claudia J. Krokos (Wife) 151 Lakeshore Drive Pasadena, Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 04/22/2011 Atlantic Cremation Glen Burnie, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 1USSIVE Physician/ disease or condition Medical resulting in death) Examiner Esquentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Live Fetal deal in the past 12 months?
1 ☐ Yes 2 ☐ No should be detached for Month Day Year the signed by Part II. Other significant conditions contributing to death but not resulting In the underlying cause given In Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has performed certificate 1 Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one examiner? Other: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 Yes 2 No 28b. Time of Certificate: 1 Natural 28d. Describe how injury occurred hours after death. Ineral Director: After 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Hospital Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [] 3 [] only one 29b. Signature and title of certifie 29c License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bortom are Washington P 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		Please	State of Mary				-	_	12576
		State Registrar			rtificate of L		R	Leg. No.	16070
Me	ician/ edical	1. Decedents Name (First, Middle, Last	ellum				2. Date of Deat	18, 2011	3. Time of Death 13:00 PM
Exa	niner	4a. Faellity Name (if not institution, give s	u Hospic	e	Ba-	Location of Deat		4c. County of Death	
Fune Direct	or	5. Social Seculity Number 6. Se 219-40-9313	7 Age //p	yrs, last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Birth	place (State or Foreign try)
Maryland 8a-f show	Director	10a. State 10b. County	100	Balti	more				0d. Inside City Limits 1 ★ es 2 □ No
n with the last 23a or 2	Funeral Di	10e. Street and Number 717 Druid La	ke Drive	Apt. 1209	10f. Zip Code	217		Og. Citizen of What Cour	ntry?
Iltimore, Maryland 21215-0036 mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. Instant: If item 27 is marked other than "natural", or items 23a or 28a-f show invitron yor other traumatic event, the Medical Examiner must be notified at	ted by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	n U.S. 13.	Was Decedent of Hill Yes, specify Cuba	in, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.
Maryland 21215-0036 2 should be filed within 72 hours after tht and Mental Hyglene. 2 ris marked other than "natural", or traumatic event, the Medical Exami	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Saconday (0-12)			dent's Usual Occup kind of work done o O NOT use retired)	during most of vo	rking	16b. Kind of Business Ind	i '
yland y Id be filed w Mental Hyg arked oth	To Be	17 Pather's Name (First, Middle, Last) Unnes C. Ke	lum, Sr				me (First Madle, N	,	
e, Mar and 2 shou Health and em 27 is m ther traum		19. Informant's Name/Relationship (Type Renital Macka	11 Cousin) 2710) Moha	WK G	iral Route Number,	Cily or Town, State, Zip C	D 21048
Baltimore, Mispermit. Page 1 and 2 st Department of Health a Important if item 27 is any injury or other tra any injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Ob. Place of Dispo demetery, creation	psittin (Name of place) patery or other place	e) 4-	22-11	20ch Location - City on M	wn, State
Bal permi Depa Impo	once	21. Signature of Funeral Service Licence	. Dreene		Vaught	s of Acility 6 (erne fu	121229	Ces
Pnysicia Medic	_	23a. Part 1. Enter the disease, or comp shock, or heat fature. List only on Immediate Cause (Final disease or condition resulting in death)	ications that caused the e cause on each line. Due to (or as a con	inon	er the mode of dying	g, such as cardiad	res iratory arre	st,	Approximate Interval Between Onset and Death
Examin		Sequentially list conditions, if any, leaving to immediate	Due to (or as a con			2001W1B1410H20			
D be executed sician and burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
8760 tificate b	Medic		d						
ivision of Vital Records, P.O. Box 68760 or Attending Physician: The law requires that the death certificate after death. Jean. Jean. Jector: After this certificate has been signed by the attending physin by the funeral director, page 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of delive Month	ery Day Year
18/11 4s, P.O. uires that the n signed by	l by Ph	Part II. Other significant conditions con	ntributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.		acco use contribute to th	
2 S S S	Completed						24a. Was ar autops	y prior to cor	osy findings available mpletion of cause of
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Vita Vita hysicia his cert	To Be	examiner?	ospital: 1	2 ☐ ER/Outpatier	Othe	he:		nce 6 Other (Specify)	HOSTINA
ivision of Vital Rector Attending Physician: The la after death. Director: After this certificate he in by the funeral director, page:	Certificate:	27. Man y of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year	28b. Time of injury	work'	rat ? Yes 2 □ No	28d. Describe how	w injury occurred	
Division Spital or Attendin hours after death. meral Director: Aft d filled in by the fur		4 ☐ Homicide determined	building, etc. (Spe	ecify)			City or Town,		
Divi Divi To the Hospital or within 24 hours after To the Funeral Dire	Medical	(Check 2 Medical Examinonly one) 3 Certifying Nurse	er: On the basis of examin	ation and/or invest	igation, in my opinio	 n. death occurred. 	at the time, date and	e(s) and manner as stated d place, and due to the cau cause(s) and manner as sta	se(s) and manner stated
5 Vitil		29b. Signature and title of certifier	une/M	9	29c. License	30/2	29	ed. Date signed (Month, E	Day, Year)
1		30. Name and address of person who co	inpleted cause of death (Item 23a) (Type F	arlas	9 1	Bith.	1/2/2	18
S	tate	31. Date filed (Month Day Year)	32. Filgistrar's Si	THE TO				1-1	

LIEDMANN MAURICE

1. Decedent's Name (First, Middle, Last) Medical Examiner 4a. Facility Name (if not institution, give street and number) Funeral Director 1. Decedent's Name (First, Middle, Last) Mourice E. Liebmann 4b. City, Town, or Location of Death ROSE GALE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	th Day Year Soll 4-25 PM 4c. County of Death 3 . Time of Death 4c. County of Death 3 . If I M OF C 9. Birthplace (State or Foreign)		
Physician/ Medical Examiner Medical Examiner 4a. Facility Name (if not institution, give street and number) Frank In Square It of a last birthday) Director Funeral Director Physician/ Medical Examiner Month 4b. City, Town, or Location of Death Rose	Day Year 4-25 PM 4c. County of Death 3c. 14: MOSC. 9. Birthplace (State or Foreign Ball Clifftore, Mary Lar) 10d. Inside City Limits 1 Yes 2 XNo		
Funeral Director 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death ROSE GOLE 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) 1	9. Birthplace (State or Foreign Ball Limore, Marylar 10d. Inside City Limits 1 Yes 2 XNo		
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Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Parkville Parkville	1 ☐ Yes 2 ☐ X No		
ទីកិទ្ធី Maryland Baltimore Parkville			
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10g Citizen of What Country?		
The second secon	USA		
Substitute Section of Section 10b. County 10c. City, Town or Location Parkville 10a. State 10b. County Parkville 10a. State 10b. County Parkville 10b. County Parkville 10c. City, Town or Location 10c. City, Town or Location Parkville 10c. City, Town or Location 10d. Called 10d. City 11d. Marchael 11d.	14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business Industry		
Elementary/Seconday (0-12) College 1-4 or 5+) life. DO NOT use retired) Mortician	Lassahn Funeral Homes		
To set the set of the	Maiden Surname)		
1 Never Married 2 Married 1 LXYes 2 No If Yes, Give	City or Town, State, Zip Code) nd 21234		
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition (Name of cemetery)	20c. Location - City or Town, State Baltimore, Maryland		
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre			
shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition and disease or co	Interval Between Onset and Death		
Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate Due to or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to or as a consequence of): Due to or as a consequence of): Due to or as a consequence of):			
d			
1 Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?	23d. Date of delivery Month Day Year		
Specific and the specif	pacco use contribute to the cause of death?		
Sp & Bon Coronary Artery Disease, Stroke, Atrial Fibrillation 104	es 2 No 3 Probably 4 Unknown		
Sprong sp	sy prior to completion of cause of		
The second of th	2 No 1 Yes 2 No		
25. Was case referred to medical examiner? 1 Yes 2 N No 1	ence 6 Other Specify)		
27. Manner of Death 28d. Date of injury 28d. Describe how injury 4 28d. Des	w injury occurred		
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Reside Responsibility 1 Yes 2 No Reside 1 Yes 2 No No No No No No No	(Street and Number or Rural Route Number, Town, State)		
The first of the f	d place, and due to the cause(s) and manner stated		
29b. Signature and title of certifier 29c. License number 2	9d. Date signed (Month, Day, Year)		
Res 0000	4/15/11		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DC Justin Linitrous 9000 Franklin Square Drive Baltimore, M	D 21237		
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	v a'al		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Items 25,27,28a-f per me, g915,05/17/2011dhb

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ April 2 0 1 1 George Ε. Lovell 08:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Linthicum Anne Arundel Tate Hospice House 5. Social Security Number 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Min June 20 1932 Director 219-28-4372 MD 78 Usual Residence of Decedent show 10a. State 10h County with the Maryland notified at 10c, City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? pe items 23a Funeral 21122 **Examiner must** 720 214th Street USA permit. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married X Yes 2 □ No
 Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: Completed White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Parole Officer 4 State of Maryland other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental I ၉ Lovell Watson George Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 214th Street, Pasadena, MD 21122 Cynthia Lovell/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot April Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 2011 Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadean, MD 21122 23a. Part 1. Enter the disease, or cor shock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, erval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): ON APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria CERTIFICAT Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year Yes 2 No g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TE121Ne DISTARDOR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform Yes 2 No 2 🗌 No 1 🗌 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ြု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 □ Nursing Home 5 □ Residence 6 🗷 Other (Specify) HOSFICE HOSSE 27, Manner of Death Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurr **Subject fell.** 28c. Injury at 5 Pending in 24 hours after deau...
the Funeral Director: Aff 1 Natural 2 X Accident 2:00 рм 04/08/2011 1 ☐ Yes 2 🗶 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Home** 28f. Location (Street and Number or Bural Route Number, City or Town, State) 720 214th Street, Pasadena, MD determined 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number APRIL 15, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARSHALL FREEMON 104MB10 MD 21045

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Physician/ 2011 06:25 AMM Albert Jacob Maggioncalda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Rock Spring Village Forest Hill 7. Age (In yrs. last birthday) If Under 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 **X** M 2 □ F Months Days Hours Min 09/19/1912 New Jersev Director 98 155-14-0396 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No MD Harford Benson 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. P.O. Box 232 21018 Page 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Aircraft Industry and Mental Hygier is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louise Travelso Jacob Maggioncalda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Evans Avenue - Timonium, Maryland 21093 Joseph C. Norris, Jr. (POA) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gds: 04/20/2011 Bel Air, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 61 11750 Belair Road - Kingsville, Maryland assa 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ thrive railne disease or condition Medical resulting in death) Examiner ementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consuquence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atter in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Osteoarthritis autopsy performed After this certificate 2 🗌 No 1 🗌 Yes 2 X No Yes Be 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Other: 1 Yes 2 XNo 4 Nursing Home 5 Residence 6 Other (Specify) Assist and Live မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 🗌 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To he Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8

Registrar DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. dm I per doc g915 5-6-11 vt State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death Leopold McLaughlin 2. Date of Death 1. Decedent's Name (First, Middle, Last) Aston 3. Time of Death Physician/ MORTH APRIL 2011 5:25 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 ★ M 2 □ F Hours FEB. 24 Year) 931 JAMAICA WI 121-30-1988 80 **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. Hant: If ifew 27 is marked other than "natural", or items 23a or 28a-f sho inty or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Yes 2 No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 USA 2806 PEMBERTON COURT Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 24 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK If Yes, Give Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) CIVIL ENGINEER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 CONSTANINE A. MCLAUGHLIN BLANCHE S. WILLIAMS 19a. Informant's Name/Relationship (Type, Print)
MARLENE A. MCLAUGHLIN/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12806 PEMBERTON COURT UPPER MARLBORO, MARYLAND 20774 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)

RIVERDALE CREMATORY 1 Burial 2 Cremation 3 Removal from State 4/18/2011 RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1, Enter the disease, or complications that caused shock, or teart failure. List only one cause on each line. Immediate Cause (Final or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): neurisum or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and -trar that initiated events resulting in death) Last Due to (or as a consequence of): burialsigned by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) 4 Pregnant a
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performe After this certificate has page 2 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 ☐ Yes 2 🔀 No မ 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Deal 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury work? 5 Pending 2 ∏ No Investigation within 24 hours after death To the Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Barbara Mitchell 19:50 PM 2011 April Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital Rosedale Square If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗹 F Months Hours Min. (Month, Day, Year) 89 213-18-6919 Director Maryland 1922 Pril 12, Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits at 10c. City, Town or Location Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Inprortant: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified once. MO 1 Yes 2 No Baltmore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21237 8107 Analee Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2. No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Conrad J. Long Brownley Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dendawan Road, Nottingham, MD 21236 Paul Mitchell / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Crematory April 16,2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Cremation and Thursa Atternatives 21. Signature of Funeral Service Licensee Pelbec B717 Green Pastures Dave, Towson, Hac Perman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate rval Between Onset and Death Immediate Cause (Final Physician/ Levkenia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 1 Yes 2 No Yes 2 XN funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Yes ျှ 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After work?
1 Yes 2 No 1 Matural injury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 🗌 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) D63054 April 15, 2011 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimone, 21237 Franklin Square Drive, Cina MD 9000

State

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death F. Mosby Theressa Physician/ Month Year PRIC Medical 4b. City, Town, or Location of Death
Burtonsville 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Sanctuary At Holly Cross Montgomery . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 228-12-8336 Months Days Hours Min 1 🗆 M 2 🕱 F 96 08/02/1914 VA Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits rector r 28a-f s notified Ellicott City MD Howard 1 XYes 2 No 10g. Citizen of What Country? ā 10f. Zip Code 21043 10e. Street and Number r must be 3125 The Oaks Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, "natural", or iter Armed Forces? Black, White, etc. þ 1 Never Married 2 Married within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Black 3 X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Own Home Homemaker 2 should be filed with h and Mental Hygier 7 is marked other t Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Alice Hollis ပ William Franklin ge 1 and 2 should be it of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6327 Wild Swan Way, Columbia, MD 21045 27 Ernest Mosby / Son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Buriai 2X Cremation 3 Removal from State cemetery, crematory or other place) 4/19/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Final Jounrey crem 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD Signature of Funeral Service Licensee Dorota Marshall ordell Mais 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death SPIRATION NEUMONIA Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached for ar significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ EOPOROSIS 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed FMENTIA 2 No certificate 1 Yes 2 No 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) Mann of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 \square Pending 1 🗆 Yes 2 🗆 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18 285 lleel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miller

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

P.O. Division of Vital Records,

within 2.

State Registrar

only one) 29b. Signature and title of certifie

Baltmore

31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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10035362

Greene St. Baltimore

Known as: Donnie Mac Oats

			Please Type or I					_		gible.		
		-	1 - State of Maryland / Department of Health and N Certificate of Death					Reg. N2 0 1 1 1 2 5 8 4				
	Physicia		Decedent's Name (First, Middle, Last) Donnie Mae Oats					2. Date of Death Amonth Day Year 3. Time of Death 2. Date of Death 3. Time of Death 3. Time of Death 3. Time of Death				
	Medic Examin		4a. Facility Name (if not institution, give street and numb	timore		4b. City, Town, or I	Location of Death	1/		ty of Death	/A	
	Funeral Director		5. Social Security Number 6. Sex	. Age (In yrs. last birt	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Nov 1	Year)	9. Birth	place (State or Foreign http:// Carolina	
		_	214-40-1918 Usual Residence of Decedent 10a. State 10b. County	10c, City, Town		ation		1404 1	1, 1941		10d. Inside City Limits	
	Marylan 28a-f sh otified a	Director	Maryland Baltimore	, see oky, tem	., 0. 200		ltimore				1 Yes 2 No	
	with the 23a or	Funeral D	10e. Street and Number 3624 Coronado Road			10f. Zip Code	21244		10g. Citizen of	What Cour		
8.0	e filed within 72 hours a ter death with the Maryland ttal Hygene. ed other than "natural", or items 23a or 28a-f show even, the Medical Examiner must be notified at	by Fun	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes			as Decedent of His Yes, specify Cuban		pecify Yes or No- o Rican, etc.)		ice - Americ ack, White,	etc.	
Lengie Mae Uatarianiand 21215-0036	ours a te stural', sal Exar		3 Widowed 4 Divorced If Yes, Give Year or Date	es.		Yes 2 X No			Specif		Black	
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ر 19 کا	filed within all Hygiene. d other than	Be	17. Father's Name (First, Middle, Last)			т-		me (First, Middle,				
Maryland	should be file n and Mental h r is marked o raumatic eve	입	Willie R. Davis 19a. Informant's Name/Relationship (Type, Print)	101	h Mailine	Address (Street a	nd Number or Ru		ashti Davi		Code	
	OL +: 52 #		Glenwood Oats, Sr.		36	24 Coronado	Road Wine	dsor Mill, Ma	ryland 212	244		
ルめい なら Baltimore,	Page 1 a nent of H int: If ite iry or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from S 4 □ Conation 5 □ Other (Specify)	tate cemete	ery, crema	ition (Name of atory or other place us Memorial F		04/21/11	20c. Location		own, State Maryland	
Kハがいり なる: Baltimore, M	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Signature a Euroral Service Lice (see	Col	22.	Name and Address	s of Facility rothers Fun	eral Service, Baltimore, M	P. A.			
7			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on eac	used the death. Do r	not enter	the mode of dying	, such as cardiac	or respiratory arr	est,		Approximate Interval Between	
Ô	Physician/ Medical		reculting in dooth)	ras a consequence		shock	2 al	thusder atrenos	which de	sene	Onset and Death	
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687	certifica nding ph use as th	Physician/Medica	23b. Was decedent pregnant	ome of pregnancy		F-4i-			23d. D	ate of deliv	very	
. Box	the atte	ysicia		irth 2 Fetal death ant at time of death wn		Other (specify)	· · · · · · · · · · · · · · · · · · ·		N	lonth	Day Year	
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physici To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	þ	Part II. Other significant conditions contributing to de	th but not resulting	in the un	derlying cause give	en in Part I.		1	_	the cause of death?	
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on of	nding Path. ath. :: After the funera	icate:	2 Accident Investigation		Time of injury	28c. Injury work? M 1 🗆	at ? Yes 2 🗌 No	28d. Describe h	ow injury occu	rred		
ivisio	l or Atte after dea Director	Certificate:		f Injury - At home, fa g, etc. <i>(Specify)</i>	arm, stree	et, factory, office				ber or Rura	al Route Number,	
Δ	Hospita Hospita Funeral ted fillec	Medical	29a. Certifier 1 Certifying Physician: To the be 2 Medical Examiner: On the basis	of examination and/o	or investig	gation, in my opinior	n, death occurred	at the time, date a	nd place, and d	lue to the ca	ause(s) and manner stated	
	To the within 2 To the comple	ž	only one) 3	the best of my know	vledge, de	29c. License	number		e cause(s) and r 29d. Date sign			
	•		30. Name and address of person who completed cause	of death (Item 23a)	(Type, Pri	DS	8736		April 1	4, 20	И	
			Zalman Kalm mo	412 Mul Ca			304 (Nestmis	ita, n	no 2	1157	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ 8:36 DUAHOD 27909 P M 1189A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIHORE-WASHINGTONMEDICAL CENTER BOUWAA UUA GLEH BURHIE 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 🛛 M 2 🗆 F Hours Min. April 13 1945 Country) Director 218-42-9251 66 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 8013 Long Hill Road 21122 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers on is marked or t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked of John Η. Ports Lillian F. Walters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Ports (brother) 8013 Long Hill Road, Pasadena, Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Apri^{Date} 20 cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State Baltimore, Maryland Matro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Sign tu of Funeral Service (io nsee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. 23a. Part 1. Enter the disease, or comp shock, or heart fature. List only on Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPTIC SHOCK disease or condition resulting in death) 2AUDH Y Medical Due to (or as a consequence of Examiner 2 MAG Y AIGOMODUS Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 LI Pregnant g I Unknown signed by the a 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 X Yes 2 No 3 Probably 4 Unknown CARYLIGEAL CANCER Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe ate 2 🔀 No 1 Yes Division of Vital the Hospital or Attending Physician: thin 24 hours after death. the Funeral Director: After this certific 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner?
1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident
Suicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completed filled Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Dingonna Sex crowdies 11753000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUILLERMO JOSE CIANGRECO 301 HOSPITAL DRIVE, CLEN BURNIE, MD 20161

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 0 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Rea. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 44 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ATONSVILL ATONS VIL Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 ☐ M 2**½** F Months Hours Min 215-24-5136 81 1*6*776774929 Maryland Director Usual Residence of Decedent show 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 XNo Baltimore Gwynn Oak Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244 United States 7017 Glen Spring Road ıral", or items 2 I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", 3 ▼ Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygene. Important. If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Spadaro Rose Termini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenwood Avenue Catonsville, Maryland 21228 Darlene Nash / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 4/21/2011 Baltimore, Maryland 22. Name and Address of Facility David J. Weber Funeral Homes PA . signature of Funeral Service 5311 Fdmondson Avenue Baltimore, Maryland 21229 Part 1. Enter the disease, or complications that caused shock, or heart failare. List only one cause on each line e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year Pregnant at time of death 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HP1 Pu DIVERDE 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 2**X** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29h. Signatu 29d. Date signed (Month, Day, Year) 20 2011 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) TO TWO IN THE LINES. el Jukens Ostromlle 21128 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Rawlings Doris E. 2011 0220 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Prince Frederick Calvert County Hospital 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🗓 F 08/07/1929 Director 81 220-28-6632 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Direct 1 X Yes 2 ☐ No Sunderland MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20689 USA 180 Gertrude Drive death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes 2 No 72 hours after Maryland 21215-0036 1 Yes 2 No Specify Specify: Black "natural", Completed 3 ¥ Widowed 4 ☐ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene. It is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Percy Chew Gladys Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a ant: If item 27 is Pattsie P. Rawlings - Daughter 180 Gertrude Drive; SUnderland, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If ii any injury or o 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Hope UMC Cemetery 4/21/2011 SUnderland, Maryland f Fy eral Say 22. Name and Address of Facility Freeman Funeral Services 21. Signature 4594 Beech Road; Temple Hills, Maryland 20748 . Enter the disease, or comp or heart failure. List only or ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between shock or heart fail Immediate Cause (Final Onset and Death Pnysician 0 disease or condition Medical resulting in death) Examiner HYPOXI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last physician HEART FAILURE Physician/Medical certificate be Box 68760 the attending IF FEMALE use ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy ō in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 🗹 No certificate Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA hin 24 hours after death. the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Statisting in state and place, and due to the case(s) and mainter as stated.
 I deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the case(s) and manner stated.
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, las

Registrar

DHMH 17 Rev 7/2009

State

100 HUSPITAL

32. Registrar's Signature

20

Prince Frederick MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sidhu

inder

Ellen Frances Robinson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar	C	ertificate of	Death		Reg	g. No.		
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,	Decedent's Name (First, Middle,Last) Ellen Frances Robinson 2. Da Mk Ap						ar	3. Time of Death 1015 hrs
	4a. Facility Name (if not institution, 1100 Pennsylvania Ave	_	4	ation of Death		4c. County			
Funeral Director	, i	7. Age (In yr 7. Age (In yr 7. Age (In yr	s. last birthday) Yrs.		f Under 24Hrs. Hours Min.	8. Date of Birth	/1936	9. Birthr Foreign Coun	CC
the Maryland a or 28a-f show any tiffed at once. Director	Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number	10c. C	ity, Town or Location		ltimore		g. Citizen of W		Od. Inside City Limits 1 Yes 2 No y?
h with the Mams 23s or 28 the notified a		nsylvania Ave		212 s Decedent of Hispan		oify Vos or No	14 Page	USA	an Indian, Black,
s after deat rral", or ite niner must by Fun	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divor 15. Decedent's Education (Speci	1 Yes 2 No reed If Yes, Give Year or Dates:	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	es, specify Cuban, Me Yes 2 X No sp 's Usual Decupation	exican, Puerto R oecify: (Give kind of wo	ican, etc.)	Whit	e, etc. Blac	ck
215-0036 se filed within 72 hour tall Hygiene. ked other than "maturent, the Medical Exar Be Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		est of working life. DC etary	NOT use retired	d)	Co	mmer	cial
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica for Be Comple	17. Father's Name (First, Middle, L			unkn.	Nother's Name (F	Rob:	inson		
e, MD 21 1 and 2 should Health and Mer item 27 is man r traumatic ev	19a. Informant's Name/Relationshi Kevin Anthony	Karteron/Son	234	Address (Street an Crystal A	venue, S	Staten :	Island,	NY 1	0302
2 : 5 : 5 : 1	4 Donation 5 Other Spe	3 Removal from State	Final Jou	tion (Name of cemete er place) They Crem	4/16	5/2011	20c. Location Woodb	ine,	MD
Baltimo pernit. Page: Department o Important: injury or oth	21. Signature of Funeral Service L	1. Marsha	IX.	ame and Address of I Mary 18 PO Bo	x 1413.	. bait	ımore,	MD	21203
Physician Vedical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Int Between Onset Death Death								
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a consequence	ence of):						
ecuted and transit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence d.							
1760, ficate be executed g physician and the builal - trans	IF FEMALE:	AMENDED 23a,		g914 4-2	6-11 vt		23d. Date of	delivery	
b. Box 687 the death certification by the attending perched for use as the Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unkn	4 Pregnant at time of	death	al death 3 let let let (Specify)	Ectopic pregnand	cy	Month	Dag	y Year
P.O. res that the signed by the detached by the detached by the bedtached by the bedtached by Plean by	Part II. Other significant condition	ons contributing to death but no	ot resulting in the u	nderlying cause giver	n in Part I.				e cause of death?
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director After this certificate has been signed by the attending completely filled it by the funeral director, page 2 should be detached for use as edical Certification: To Be Completed by Physician						24a. Was a autops perform	y ned?		psy findings available mpletion of cause of 2 No
Physician: The Physician: The Interest of Interest or	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient		Death (Check on		Residence 6	🖊 Other: S	Scene
Sion of Attending Ph r death. ector After t by the funeral	27. Manner of Death 1 X Natural 5 Pendir 2 Accident Investi	gation	28b. Time of Ir	1 Yes	2 No		ow injury occur		I De de Nembra Cit
Division o Beapital or Attending 24 hours aft r death. Flueral Director Aft stely filled is by the fune all Certification:	4 Homicide determ	(0,0003)				or Town, St	ate)		I Route Number, City
To the Ho within 24 P To the Fun completely	(Check only Certifying Fit)	rsician: To the best of my know			eath occurred at t			due to the	cause(s)
	Julitate	er Velt	36	O.C.M.E			April 8, 20		
0	30. Name and address of person v Victor Weedn MD JD	Assistant Madical Ever	minor 111 D	enn Street, Balt	imore, MD 2	1201			
State Registrar		32. Registrar's Sign	parket						

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Katie Scalper 101 M APM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospice Center Randallstown Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □ M 2 🔀 F 63 Days Hours (Manth, Day, Year) 8 214-50-0653 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City. Town or Location Director ▼ Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö #611 permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r Funeral 501 E. Preston Street Apt. 21205 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, et African 11. Marital Status Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes XX No Specify: Specify: American Completed 3 Widowed 4X XDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Circular Elementary/Seconday (0-12) College (1-4 or 5+) Advertising 10th Grade Packer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Susie Mae Mack Elliott Smith, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2318519a. Informant's Name/Relationship (Type, Print) Lisa Givens-Daughter 7115 Pocahatas Trail Williamsburg, VA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

. Zion Cem. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lansdowne, MD 04-26-11 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Street Baltimore, MD 21217 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Esophageal Concer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performe Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗖 No Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death the funeral 28b. Time of 28c. Injury at work?
1 \sum Yes 2 \sum No 28d. Describe how injury occurred 1 Natural injury 5 Pending ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title title of certifler JMM-D 29d. Date signed (Month, Day, Year) D0057465 4/18/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S RAMARKHOD 934 NOTON BIVO 21061 32. Registrar's Signature State par Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** April 01: 23 PM 17 ude 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore NIA Hospital city 4 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Aug. 12 Birthplace (State or Foreign Country) **Funeral** Year 76 Months Days Hours 1 M 2 F 218-28-7694 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Hres 2 No Director Honore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or 2120 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Warried Baltimore, Maryland 21215-0036 Specify: 1 ☐Yes 2 ☐NO Specify: \$ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatin. Elementary/Secondary (0-12) College (1-4or 5+) OVK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Type. Print) Informant's Name/Relationship Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Deurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Lineral MD 21207 4600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final meumonia Physician Aspiration disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Severe Alzheimer's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-1 Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the attending phase as the IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Mellitus 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate 2 X No 2 X No 1 🗌 Yes 1 ☐ Yes Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MBBS / Shoudhar April 17, 2011 RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Jyohi 31. Date filed

Chaudhary

MBBS

32. Registrar's Signature

Hospital

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, 11-02865 State of Maryland / Department of Health and Mental Hygiene Norman Springer Certificate of Death 1. For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ April 15, 2011 0939 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) tc. County of Death 4b. City, Town, or Location of Death Harford Forest Hill 2329 Roack Spring Road 5 Social Security Number 6 Sex 7. Age (in yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Min. Davs Hours Months Country) MD Director 1 X M 2 F 217-36-3131 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County Yes 2 No use 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

The may 1 an anked other than "natural", or items 23a or 23a-f she then than matured out the them than matured by the Modital Examiner must be notfited at once. ND Director 10g. Citizen of What Country? 10e Street and Number 21050 500 uneral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 🔀 No Yes ũ If Yes, Give Yeer 1 Yes 2 No specify: Specify: White 3 Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2, 228 ဥ 19a. Informant's Name/Relationsh Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Pages 1 Allentown, PA 4 Donation 5 Other Specify 21. Signature of Puneral Service Licer 22. Name and Address of Facilities JESSUP, PA 18434 midualle DX . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and ilure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease mediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause. (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED the attending physician red for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth Yea 3 Ectopic pregnancy Month Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' Yes 2 ✔ No 1 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work' 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 V Natural 1 Yes 2 No death. Pending Director: the Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City hours after 3 Suicide Could not be or Town, State) within 24 hours a determined To the Hospital Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 16, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 0 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Julia Isabe1 Stanton April 2011 12:09 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth April 13,2011 6. Sex Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Maryland Director None Yrs. Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at Director MD Montgomery Kensington 1 X Yes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 11122 Newport Mill Rd. 20895 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event. the Medical Examin 1 X Never Married 2 Married Completed by Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Specify: 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) None 0 Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Stanton Amy Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Stanton / Father 11122 Newport Mill Rd., Kensington, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Lakeview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Clarkston, MI (Unknown) Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 21. Signature of Juneral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) EXTREME PREMATURITY Medical Due to (or as a consequence of) Examiner PLACENTAL INSUFFICIENCY Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi) The law requires that the death certificate be executed Cause (Disease or linjury physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 ending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death the P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed Yes 1 🗌 Yes 2 🗌 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical director 26. Place of Death (Check only one) Be examiner? Hospital: Other: Certificate: To 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deal Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

1aula

31. Date filed (Month, Day, Year)

APR 20 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRYSANTHE GAITATZES, M.D.

32. Registrar's Signature

D0066134

1500 FOREST GLENN RD., SILVER SPRING, MD

41

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b, perFH, G915, 5/13/2011, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4-13 Day Physician/ 8:07) PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgome Adventist oma ar 9. Birthplace (State or Foreign Country) Security Number If Under 24 Hrs. 6. Sex If Under 8 Date of Birth **Funeral** 1 M 2 □ F Months Hours **Director** Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important If item 23a or 28a-f sho amy injury or other transities of the Maryland of the Maryland Amy injury or heart ammatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No rinc 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 2 No 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) EDS oecia 1 Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wertz laurice Place of Disposition (Name of demetery, cremators or other place, 20a. Method of Disposition 20 Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 Donation 5 Other (Specify) 1000 5-10-2011 22. Name and Address of Facility Vaugun C. Greene Funera Services 21. Signature of Funeral Service License Ilstown. 23a. Part 1. En et the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ rebr inte Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi) Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 100 Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending injun 1 Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060 60 04-14-11 F 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alfmina K Almes BLVD Sags Sin MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Susie .10 PM 2011 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death Examiner Baltmore 1-10spital Good Samaritan 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 Ø F Months Days Hours 217-70-003 2104/1947 North Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shov 1 XYes 2 ☐ No Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7202 McClean Boulevard 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 Widowed 4 Divorced Ith and Mental Hygiene.
It is marked other than "natur traumatic event, Ity Wedical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cicero Moses Della Mae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gloria Benjamin (Sister) Health tem 27 i 701 Beaumont Avenue, Baltimore, MD 21212 permit. Pages 1 and Department of Healt Important: If Item 27 any injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Removal from State Ardent Crematory 4/22/2011 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD 21. Signature of Funeral Service License 22, Name and Address of Facility Phillip A. Weatherford FS 2431 E. Oliver St., Baltimore MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Right **Physician** Pleural /Medical Due to as a consequence of): Examiner Rightlungs preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit signed by the attending physician and be detached for use as the burial-transi Lungs ano Division of Vital Records, P.O. Box 68760, 1et astati Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 🗷 □ No 2/2 No 1 ☐ Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier P25318 29d. Date signed (Month, Day, Year) Nyan Phyo MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Lock Raven Blud, Baltimore MD NYAN PHYO MD. Registrar's Signature 31. Date filed (Month, Day, Year) State 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Juanita Tracey April 19ay 201 gar 2:25 а м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔏 F 217-26-4446 Hours 82 Jul Meth. 2 ay. 1928 Maryland Director Usual Residence of Decedent 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 🗆 Yes 2 ื No Penn. York Manover 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Larch Drive 17331 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? 1 ☐ Yes 2 🐼 No Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. nan "natural", Medical Exar If Yes, Give 3 XWidowed 4 Divorced White Completed Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Maryland Public Elementary/Seconday (0-12) College (1-4 or 5+) Secretary traumatic event, the Television Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental ပ္ Page 1 and 2 should be Marie Miller Louis Kelbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 142 Webal Ct. Severna Park, MD. 21146 Edward Tracey, Jr. - son 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. ō 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Finksburg, MD. Evergreen Mem. Park April 23,2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, MD. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ ON neum Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury and -trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day been signed by the should be detached 1 ☐ Yes 2 L 9 ☐ Unknown P.O. significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? this certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes မ 1 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify, eral Director; After th filled in by the funeral Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending death. Accident Suicide Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD pleted cause of death (Item 23a) (Type,

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 0 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

cille Thomas		State of l	Maryland / Departn <i>Certifi</i> d	nent of I cate of I		and	Mental I	Hygiene	Reg. No.	201	1 1259
Physicia edical Examin	1/ 1	. Decedent's Name (First, Middle,Last) Lucile	Thomas					2. Date of D Month April 9, 2	Day	Year	3. Time of Death 1115 hrs
	4	la. Facility Name (if not institution, give stre	eet and number)	4b	. City, Tow Baltimo		cation of Dea			c. County of Deat	
Funeral Director		6. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday) Yrs.	If Under	Year Days	If Under 24H Hours M	in		l Forei	rthplace (State or gn ountry) Texas
ow any	Ī		10c. City, Tow Balti		n						10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show any notified at once.	Director	Oe. Street and Number			10f. Zip Co	1230)		1	itizen of What Co	untry?
eath with the items 23a court he notified	L	640 S. Charles St 11. Marital Status 1 X Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? Yes 2 X No		Decedent	of Hispa	nic Origin? (Specify Yes or rto Rican, etc.)			erican Indian, Black,
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23s or 28a-f she martie event, the Medical Examiner must be notified at once	ᇍ	3 Widowed 4 Divorced of Your 15. Decedent's Education (Specify only h	es, Give Year Pates: Ighest grade completed) 16	a. Decedent		cupation		of work done	16b	Specify: B1a	
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner	Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4 or 5+) 5+	Representative				nne (First, Midd	le, Maide	USA en Surname)	
21215-0036 and be filed within 7 Mental Hygiene, marked other than c event, the Medic	Be	Fred 19a. Informant's Name/Relationship (Type,	Thomas			(Street a	Luci	11e or Rural Route	Number,	Hearne City or Town, Sta	nte, Zip Code)
무성분들		Ethel Thomas (20a. Method of Disposition 1 Burial 2 K Cremation 3		e of Disposi	tion (Name	of ceme	etery,	ttle WA	98	C. Location - City	or Town, State
Baltimore, permit. Pages l at Department of He Important: If ite		Burial 2 K Cremation 3 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	@ Loud	don Pa	rk ame and A	ddress o	of FacilityLo	/18/11 udon Pa	rk F	uneral H	Maryland
Physician									Approximate Interval Between Onset and Death		
Medical	Lypertensive Atherosclerotic Cardiovascular Disease								Bedui		
	Examiner										
be executed sician and urial - transit											
Box 68760, cleath certificate be execut the attending physician and ed for use as the burial - tra	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 Live birth 4 Pregnant at time of death	2 Fe	ital death	з [fy) _	Ectopic pre	egnancy	_	23d. Date of deliv Month	very Day Year
the ed to	by Phys								23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknow		
of Vital Records, P.O. Box 68760 ng Physician: The law requires that the death certificate there this certificate has been signed by the attending phymeral director, page 2 should be detached for use as the b	Completed								Was an eutopsy performe res 2 ⊌	pnor death	e autopsy findings available to completion of cause of n? Yes 2 No
	Be Co		spital: 1 Inpatient 2 E	R/Outpatien			Othor	eck only one) ursing Home	Res	sidence 6 ✓ 0	ther: Scene
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	ion: To	1 ✓ Yes 2 No 27 Manner of Death 1 ✓ Natural 5 Pending	28a. Date of Injury (Month, Day,Yeer)	28b. Time of		_	y at Work?		ribe how	v injury occurred	
Division of Vipital or Attending Phours after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Roor Town, State)							Rural Route Number, City		
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner:	n: To the best of my knowledge on the basis of examination and and manner stated.	e, death occu d/or investiga	ation, in my	opinion	, death occur	, and due to the red at the time,	date and	d place, and due t	o trie cause(s)
To writi	Me	29b Signature and title of certifier Meller Browner	(M)		290	O.C.	e number M.E.			April 12, 2011	(Month, Day, Year)
7		,	sistant Medical Examine	er 111	Penn St	reet, E	altimore,	MD 21201			
Regi:	tate stra		32. Registrar's Signature		del						

DHMH 17 Rev 1/2001

0041

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-02408 State of Maryland / Department of Health and Mental Hygiene Gerald Harry Treffinger 1- For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ March 28, 2011 2025 hrs Medical Examiner Gerald Harry Treffinger a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Pasadena Anne Arundel 114 Cloverhill Road D If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** 01/29/1944 Min. Country) MD 220-40-7940 67 Months Davs Hours Director Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD Pasadena Anne Arundel 1 Yes 2 X No permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", ur items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 114 Cloverhill Road 21122 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funera 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes Specify: White 4 Divorced If Yes, Give Year 1 Yes 2 No specify: ≦ 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DD NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Music MD 21215-0036 Musician 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herman John Treffinger Kathleen Mary Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brother 10973 Hilltop Lane Columbia MD 21044 Paul Raymond Treffinger 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State timore, Attranticie de la crem 04/16/11 Glen Burnie MD Donation 5 Other Specify: 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of F eral Service Licent ThomasAllenPA 7090 Ridge Rd Hanover 23a. P. rt I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a,pt.II,27 per me g914 4-22-11 vt X UNPENDED attending physician for use as the burial requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 Yes 2 No 3 Probably 4 V Unknown Chronic Obstructive Pulmonary Disease COPD) Completed has been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed 1 🗸 Yes page 2 No this certificate ✓ Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending the 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 hui March 29, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD

State

Registrar

31. Date filed Month, Day Year

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32. Registrar's Si

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 17, Day 2011 Year Physician/ 8:00 Varveri (NMI) James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie 107 Crest Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Days Hours Min. Sept. D26 (ear) 1927 Nebraska 83 Yrs 212-26-4742 **Director** Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location 10a. State 10b County must be notified at Director Baltimore 1 Yes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 by Funeral 23a 1002 Pine Heights Ave permit. Page 1 and 2 should be filed within 72 hours after death Inportant If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner may injury or other traumatic event, the Medical Examiner may 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 K Married 1 Yes If Yes, Give White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Printer Pressman 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eden ဂ Varveri Christopher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1002 Pine Heights Ave., Baltimore, MD 21229 (Wife) Ruth Varveri 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 4/22/11 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. — There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final can diac Physician/ disease or condition Medical resulting in death) as a consequence of): **Examiner** cardiomyopah Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? for Pregnant at time of death Yes 2 No g ☐ Unknown g 🗌 Unknown signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Hypertmsin 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) daughter! Hospital: Other: ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation after death 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours after Funeral Dire leted filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifie D25861 April 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bruce R. McCurdy, MD. 716 Maiden Choice Lane Suite 101 Baltimore, Maryland 21228

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 9:00 P M Physician/ April 2011 Lynn Rose Winters Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Clinton Prince George's Southern Maryland Hospital 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Country) 1 M 2 X F Months 6.1952 224-80-2854 58 Director Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County event, the Medical Examiner must be notified at Director X Yes 2 No Prince George's Upper Marlboro 10g. Citizen of What Country? 10e Street and Number ò Funeral 23a 2201 Manor Gate Terrace 20774 USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 X Married 0 by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black "natural" 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Private 4 yrs Consultant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Queen Esther Lewis Dewayne Bush other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) rmit. Page 1 and 2 sh spartment of Health ar critic it item 27 is y injun or other trau 2201 Manor Gate Terrace, Upper Marlboro, MD 20774 Lawrence E. Winters 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition K Burial 2 ☐ Cremation 3 ☐ Removal from State 04/18/2011 Landover, Maryland Harmony Cemetery 4 Depation 5 Other (Specify 22. Name and Address of Facility J.B. Jenkins Funeral Home Signature of Jun an Service License 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 151 Physician/ disease or condition resulting in death) Medical Examiner neumonia Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Hospital or Attending Physician; The law requires that the death certificate be Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Month Day in the past 12 months?

1 Yes 2 No
9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by History 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available Netastatic 24a. Was an prior to completion of cause of death? autopsy performe No 1 Yes Yes 26. Place of Death (Check only one) Division of Vital Be 25. Was case referred to medical examiner? Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျာ 28b. Time of 28c. Injury at 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) work?
1 Yes 2 No injury within 24 hours after death.

To the Funeral Director: Afte completed filled in by the funeral process. 1 X Natural 5 Pending M Investigation 6 Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 12011 20735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 SURRATTS ROAD State 2 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Beverly Ann Weber 8:50 A. M April 14 2011Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months 1 □ M 2 🛣 F May 25 217 40 2865 67 Maryland **Director** 1943 Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Severn 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8088 Quarterfield Road U.S.A. 21144 within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Ş 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Retail 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) snould be file th and Mental H permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev Henry Weber Sr. Mildred Herbert 2011 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances O'Brien / sister Baltimore, Maryland 21225 110 - 2nd Avenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 04/18/2011 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Glen Haven Mem. Park of Fu eral Service License Signatu 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Ph sician PANCREATIC CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or se a consequence on) cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has le 2 s autopsy prior to completion of cause of death? certificate ha BEVERLY 2 🗆 No 1 Yes Ves funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** 1
Yes 2 🗶 No မူ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 X Natural 5 Pending 1 Yes 2 No M Investigation Il Director; / Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certife signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES 2300 DULANEY VALLEY RD. CRNP TIMONIUM, MD 21093 State Registrar

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 16, 2011

perd OCME

29b. Signature and title of q

Mary G. Ripple MD.

31. Date filed (Month, Day, Year) 32. Registrar's Signature **ORIGINAL**

Deputy Chief Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death Time of Death 4:10p_M Fred Harry Waldrup Physician/ 04709/2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Stella Maris Baltimore Timonium 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 07/31 / 1968 bE 262-79-6982 42 **Director** Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Examiner must be notified at Director Elkton Cecil MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Elkton 243 E Main Street Apt 3 Funeral items 23a USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by "natural", or ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturn any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired)
ROOTEr Elementary/Seconday (0-12) College (1-4 or 5+) Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eular Waldrup Jr Mary Ann Letner ^{19a.} Informant's Name/Relationship (Type, *Print*) Mary Ann Zitter Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 243 E Main Street Apt 3 Elkton MD 21921 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Glen Burnie MD Place of Disposition (Name of $04/1^{\frac{1}{3}}/201^{\frac{1}{3}}$ A terleam terratory Corne Hace) 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv of Faneral Service Licer ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): $FRED \quad WALDRUJ$ Division of Vital Records, P.O. Box 68760 Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No cate has been signed by the atte page 2 should be detached for it Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 Natural 2 Accident 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Year 0 31. Date filed (Month, Day, State 2 APR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1.45 m M 201 Medical Facility Name (if not institution, give street and number) 1212 Odenton Rd Apt 424 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Odenton Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Min. 05/24 Country) 1935 MA **Director** 010-26-2792 iral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location **Funeral Director** Anne Arundel Odenton MD 1 🗆 Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1212 Odenton Road Apt 424 USA 21113 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No Specify: Specify: White If Yes, Give 1957-59 Year or Dates. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna Elsie Sallstrom Frederick Wehage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2747 Shandon RD Rock Hill SC 29730 Kathleen Craig Daughter 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot AtTantic 04/20/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Simplicity Crem and Fun Thomas Allen PA 7090 Ridge RD Hanover Serv MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a onsequence of): **Examiner** S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L retai 3000 Pregnant at time of death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No been signed by the atte Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed ☐ Yes 2 No 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 📆 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 🗌 No Accident Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) 20 (1 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 2074 Shington RD Suite 206 Ft Washinston Registrar's Signa State Registrar

Juwarren Williai	ms	State State	of Maryland / Dep		ealth and Menta	Hygiene	2011	12505
Physici	ian/	1. Decedent's Name (First, Middle, La				2. Date of Dea	eg. No. th	3. Time of Death
Medical Exam	iner	Ivwarren		ams		April 15, 2	Day Year 2011	1029 hrs
		4a. Facility Name (if not institution, gi St. Agnes Hospital	ve street and number)		ity, Town, or Location of Daltimore	eath	4c. County of Death Baltimore Cou	
Funeral		Social Security Number 6. S	Sex 7, Age (In yrs.		Under 1 Year If Under 24	Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bir	
Director		214-89-9473 1	M 2 F	N			Foreig	
		Usual Residence of Decedent	3 <u></u>		70101			
w aoy		10a. State 10b. County		, Town or Location		-		10d. Inside City Limits
yland -f.sho	tor	10e. Street and Number		Bach				1 Yes 2 No
5-0036 ed within 72 hours after death with the Maryland iygiene. other thao "natural", or items 23a or 28a-f sho the Medical Examicer must be notified at once.	Director	228 N .	Culver S	ナ・ 100	Zip Code 2/27		Og. Citizen of What Cou	ntry? A
h with	Funeral	11. Marjtal Status	12. Was Decedent Ever in U		cedent of Hispanic Origin? pecify Cuban, Mexican, Pu			can Indian, Black,
	Fun	1 Never Married 2 Married	1 Yes 2 No		/	eno Rican, etc.)	White, etc.	Spell
215-0036 be filed within 72 hours afte ntal Hygiene. rked other than "natural", cot, the Medical Examiner.	Ş	Widowed 4 Divorced Divorced Specify of the state of the s	d If Yes, Give Year or Dates:		2 No specify:	of work done	Specify: 16b. Kind of Business/	of FFGC
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21215-0036 uld be filed within 7 Mental Hygiene. marked other thao	o Be	Jeffes 19a. Informant's Name/Relationship (Type Print)	a ms	ress (Street and Number	era	High	To Oudo)
MD 12 show th and I 27 is rum affice	۲	Ciera High -	mother	228 N	Culver S	$t \cdot Bata$	b, md. 2	-1229
. 5 2 2 2		20a. Method of Disposition	20b.	Place of Disposition crematory or other pl	Name of cemetery,	Date	20c. Location - City or	
imore Pages 1 nent of H hant: If is or other		1 Burial 2 Cremation 3 4 Donation 5 Other Specify	Removal from State	T. Zw	n cem 4	-21-11	Lansdn	me, mD.
Baltimore permit. Pages 1 s Department of H Important: If it		Sonature of Funeral Service Licer		22. Name	n CEM 4 and Address of Facility 3	405 W.	Fran Klin	so.
	10	23a. Part I. Enter the disease, or comp	lalla	celNan	cy m. wae	lace F.S.	Batto. n	d.21229
Physician //Medical		failure. List only one cause on ea	ach line.				est, shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease a. or condition resulting in death)	Sudden Unexpla Due to (or as a consequence of	ilned Deat	h In Infancy	(SUDI)		Deau
		Sequentially list conditions, b.						
	nine	cause. Enter Underlying Cause	Due to (or as a consequence o	of):				
sit sit	Examiner		Due to (or as a consequence o	of):				
be executed ician and urial - transit	dical	d. X UNPENDED		27.00		· · · · ·		
50, te be e nysicia	Medi	IF FEMALE:	AMENDED 4c, 23a, 2	27,28a-f,p	er me,g916 6	-8-11 sm	Lood Date of dating	
5876 rrtifica ling ph	an/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal de	ath 3 Ectopic pre	gnancy	23d. Date of delivery Month D	ay Year
Box 68760 e death certificate b the attending physied for use as the bu	Physician/Me	1 Yes 2 No 9 Unknown	4 Pregnant at time of de	eath 5 Other (Specify)			
t the d		Part il. Other significant conditions		esulting in the underl	ying cause given in Part I.	23e. Did to	bacco use contribute to t	he cause of death?
ires that the signed by	d b					1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
ords w requi	ete				- 1	24a. Was a		opsy findings available
Division of Vital Records, tal or Atteoding Physiciae. The law requirers after death. al Director: After this certificate has been side in by the funeral director, page 2 should be	E O	24a. Was an autopsy findings av prior to completion of cau death? 1 ✓ Yes 2 No 1 ✓ Yes 2						
Vital Reco	Bec	25. Was case referred to medical examiner?			26.Place of Death (Che			2 No :
F Vit	2	1 ✓ Yes 2 No		ER/Outpatient 3			Residence 6 Other:	
n of oding Ph. h. the funeral	ë	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe h	ow injury occurred	
isior Atteoder death	icat	2 Accident Investigation	28a Place of Injury - At he	fd 9:10am		Unknown 28f Location (S	treet and Number or Rur	al Route Number City
Div	Certification:	3 Suicide 6 Could not I determined	pe	,,,	, ,	or Town, St	ate)5701 Baltimo altimore,Md	re National
Division of Vital Records, P.O. Box 68760 To the Hoppital or Atteodug Physicker. The law requires that the death certificate b within 24 hours after death. To the Functial Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu		29a. Certifier 1 Certifying Physici	an: To the best of my knowledge: On the basis of examination ar			nd due to the cause	e(s) and manner as state	d.
To t with To t	Medical	29b. Signature and title of certifier	and manner stated.		29c, License number	at the time, date a	29d. Date signed (Mon	
		him ho	Wa		O.C.M.E.		April 16, 2011	, = -,,,
	ŀ	30. Name and eddress of person who o	1	23a)				
			edical Examiner 111		Iltimore, MD 21201			
Sta Regista	-	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	barre				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State 2606 Certificate of Death Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ DELORES W. ZORNAK 5:40 P April 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Summit Park Health and Rehabilitation Center Baltimore Catonsville 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Davs Hours Min 1 M 2 W I 219-28-2456 89 Director Mary land Jsual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits at 10a. State 10c. City. Town or Location Director "natural", or items 23a or 28a-f s dical Examiner must be notified Maryland N/A 1 X Yes 2 No Baltimore 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 1810 Jackson Street 21230 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Building Services Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. BGE Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic and once. and Mental I is marked o ပ Gramble Goode Margaret E LeClar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicholas Zornak (Son) 3543 Horton Avenue, Baltimore, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Bayview Crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4/20/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee Kevin E Ecker McCully-Folyniak Funeral Home, P.A. 22. Name and Address of Facility 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PNEUMONI Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and s the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Year Month Pregnant at time of death signed by the a d be detached for 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ GASTRO-INTESTINAL BLEED 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of CONGESTIVE HEART FAILURE 24a, Was an performe 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 No ER/Outpatient 3 DOA မ 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18/ Dec & 5861 (Vi) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HASAN AWAN 2717 HAMMONDS

State Registrar

DHMH 17 Rev 7/2009

. Date filed (Month, Day, Year)

APR 20

32. Registrar's Signature

FERRY RD BALTIMORE, MD 21227

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State AMEND#17 perFH. 4/4/11; DW: MOCOCertificate of Death 2. Date of Death Day 2 Month Physician/ 4 0304 M MEKONNEN Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgener ONNE If Under 24 Hrs. 8. Date of Birth . Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 **Funeral** 1 □ M 2 🗹 F one Min 55 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10h Count 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland or other traumatic event, the Medical Examiner must be notified at Director AShiNaton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral S 20012 710 or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Blac Specify. "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) eacher Be 17. Father's Name (First, Middle, Las Mekonnen 18. Mother's Name (First, Middle, Maiden marked 2 AREDO Department of Health and I Important: If item 27 is many injury or other traums 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD NEICH Genet aNH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State ABABA 4 Donation 5 Other (Specify) BACON FUNERAL HOME, INC. permit. Signature of Funeral Service Licent atric 2010 ain 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner 9 Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit. that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. • Funeral Director: After this certificate has been signed by the attending physicial. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown Kena Cel 2 No 3 Probably 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dilat autopsy performe Kespiratory 1 Yes 2 No Yes 2 No 25. Was calle referred to me callexaminer? Be 26. Place of Death (Check only one) Hospital: မ ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one 3 [29b. Signat 29d. Date signed (Month, Day, Year) 66249 and address of person who completed cause of death (Item 23a) (Type, Print) 30. Nar Forest Glen Rd, Silver Speing NID Z 09/0

Registrar DHMH 17 Rev 7/2009

State

than

0 4 201

JONE Date filed (Month, Day, Year) 1500

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month March Katherine Andrews 4:45am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Renaissance Gardens - Riderwood Silver Spring If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Social Security Number 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Director 201-14-4596 90 Pennsulvania Usual Residence of Decedent 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No Maruland Prince George's Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 U.S.A. 3156 Gracefield Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 Yes 2 No Completed by 1 X Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Andrews Mary Lenhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3156 Gracefield Road, Silver Spring, MD 20904 Jeanne Hayes - Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State St. Dominic Cemetery 04/02/2011 Donora, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, o proplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. Interval Between Onset and Death Immediate Cause (Final Physician/ Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) Unknown Medical Examiner Unknown Diabetes Merritus. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month 5 Other (specify) 9 Unknown detached ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, To the Hospital or Attending Physician; The law requires Hupertension 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 X No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Acertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number R158667 March 29. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3160 Gracefield Road, Silver Spring, Eileen Gemmell. CRNP Maryland 20904 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

APR 0 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 12609 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ellen Elizabeth Arthur April Day 2011 Year 3 6:49P. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hillhaven Assisted Lvg. Nursing & Rehab Center Adelphi . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F 88 Hours Min Dec. 30, 1922 220-34-2741 Director Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director College Park Maryland Prince George's 1X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 5203 Mangum Road 20740 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🕅 No Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Secretary Be 17. Father's Name (First, Middle, Last) 18, Mother's Name *(First, Middle, Maiden Surname)* Jennie Frederick ပ John McKinney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8610 Jefferson Street Bethesda, Maryland 20817 Jesse T. Arthur, Jr. -son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cometery crematory or other place)
Fort Lincoln Cemetery 4/8/2011 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bonald Words Bofg Wardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Cerebrovascular Accident Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Atrial Fibrillation Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, Hypertension Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events use as the burial-tru Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Hyperlipidemia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 ☐ Fetal dea
 Pregnant at time of death Day 5 Other (specify) Month ed by the a detached f 9 Unknown is certificate has been signed by director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. $Sjogren's\ Disease;\ Dementia$ 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes 2 \(\sum \) No 24a. Was an autopsy performed? Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify, Hospital: 2 XNo မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director; After this in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 31. Date filed (Month, Day, Year) APR 05 2011

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas E. Maslen, M.D. 7525 Greenway Center Drive, #312 Greenbelt, Maryland 20770

MD

the

2

29c. License number

D55559

29d. Date signed (Month, Day, Year)

April 4, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 3, 2011 1:45 ам Michael Andrew Anselmo Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Friends Nursing Home Sandy Spring 8. Date of Birth (Month, Day, June 3 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Min 1 3 M 2 D F 95 Hours Country) Director 579-07-2195 D.C. 915 June Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director notified MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number items 23a or ner must be n ō 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 IISA 1010 Briggs Chaney Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 5 þ 1 Never Married 2 Married Yes, Give T.T.J Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White "naturaf" 3X Widowed 4 ☐ Divorced Year or Dates, WWII Completed of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Developer Own Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Angela Gatti Andrew A. Anselmo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: if item 27 is any injury or other trau 1317 Colesberg Street, Silver Spring, MD 20905 Joan Anselmo Hobbs/Daughter altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4/7/11 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Signatu Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring MD 20901 23a. Part 1. Enter the disease, or shock, or heart failure. List only omblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, you cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and I for use as the burial-trace Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? been signed by the atte should be detached for Month Day Year Pregnant at time of death ☐ Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Hemophililia, Clostridium Difficile Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 AN death? 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: XX | Nursing Home | 5 | Residence | 6 | Other (Specify) 1 Yes 2 K No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' ☐ Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) d18726 April 4, 2011 iD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arthur Schoengold, MD 10111 Prince Philip Drive, Olney, MD 20832

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 05 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Appendi 1 7 pay 2011ear Physician/ Manouchehr Adamiyat 1:45A. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Montgomery 8904 Tuckerman Lane Potomac 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 97 March21 Year 914 219-63-8106 Iranin) **Director** Usual Residence of Decedent show 10a. State 10b. County ıral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Potomac 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8904 Tuckerman Lane 20854 Iran Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. altimore, Maryland 21215-0036 within 72 hours after White 1 ☐ Yes 2X No Specify. "natural", Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Professor Education of Health and Mental Hygiei item 27 is marked other other traumatic event, the Be 18. Mother's Name *(First, Middle, Maiden Surname)* Toba Adamiyat 17. Father's Name (First, Middle, Last) ည Department of Health and Ment.
Important: If item 27 is marked any injury or con-Abasgholi Adamiyat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 8904 Tuckerman Lane Potomac, Maryland 20854 Azadchehr Mokhtari -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4/8/2011 Parklawn Mem. Park Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licer Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or restiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final 3 Weeks Death Ph sician/ Subdural Hematoma disease or condition Medical resulting in death) Due to (or as a consuluence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence or -burialphysician s the burial Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death the 9 Unknown Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has page performed? Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1X Yes 2 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3/2011 Pay, Year) 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur unk probable fall 2 X No 1 Tyes Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined. found: Specify Found: 8904 Stockerman La. Potomac, M208.4 Medical 29a, Certifie 1 🔀 Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 7, 2011 D53269 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 5616 Shields Drive Bethesda, Maryland 20817 ALL 1....31. Date filed (Month, Day 32, Registrar's Signature State Registrar

De

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ RICHARD **EUGENE** BITTLE 2108M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 8, 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Days 1 🕅 M 2 🗆 F 92 Marvland **Director 19**18 220-10-3685 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 21740 USA 1104 Potomac Avenue Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner ō þ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U. S. Government Supply Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Summers Bertha Emory Luther Bittle May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13120 Hepplewhite Circle, Hagerstown, MD 21742 it of Health a Amy Brady/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department o Important: If any injury or ò 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State St. Paul's Lutheran Apr.15,2011 Myersville, Maryland 4 Donation Other (Specify) Service Licensee 504 Main Street Signature of Funera 22. Name and Address of Facility Myersville, MD 21773 Ricketts Funeral Home telle 23a. Part . Enter the di complications that caused shock or heart fail re. List only one cause on each line omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? R 2 1 No 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ပ 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 Tes 2 🗆 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler (Check Eqrtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title o 29d. Date signed (Month, Day, Year) 00065024 201

State Registrar 31. Date filed (Mon

1116 Medical Camais Rd

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 2011 8:09 AM Physician/ D NOMAS Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Charles LaPlata Civista Medical Center g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 5. Social Security Number **Funeral** Maryland Months Days Hours Min 1 **X** M 2 □ F Yrs 55 Director 212-66-4195 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Machine. 10c. City, Town or Location 10a. State Director 1 🛣 Yes 2 □ No Waldorf Charles Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20602 1603 Boarman Ct 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Yes 2 No1980 If Yes, Give Year or Dates. 1974 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S.Postal Service Truck Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ೭ Bell Mary D. Green James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1603 Boarman Ct.Waldorf MD 20602 Bonita Bell/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Maryland Veteran 4/13/11 Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility . Signature of Julieral Service Licensee Adams Funeral <u>Home Pa, Aquasco MD 20608</u> 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscleration CATGLEVASCULAR Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** me Abetas Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Io the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has how city completed filled in by the first Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant Month Year in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2. No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No ☐ Yes 2 No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

1 Yes 2 No Be Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Manner of Death Date of injury (Month, Day, Year) Certificate: 1 Natural 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titl of cer mo 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Suck 302 Walder f mo 20402 12010 old line Pace Center 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Day 2011 Year Physician/ April 4, 2:47 PM Roberta Ann Boscia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 41 Anchor Way Drive Ocean Pines Worcester If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth g. Birthplace (State or Foreign Country) **Funeral** Min. Days Hours 1 □ M 2 🔀 F Feb. 12, 218-64-6972 57 1954 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Ocean Pines Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 41 Anchor Way Drive 21811 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced white Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Je filed wru.. *tal Hygiene. *her than "r Elementary/Seconday (0-12) College (1-4 or 5+) should be filed withing and Mental Hygiene 27 is marked other the wastic event, the Nurse Private Doctors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Mary Alice Nolen John J. Duffy permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anchor Way Dr.Ocean Pines, MD 21811 Leonard Boscia-Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State State Crem. 4-5-2011 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William Street Berlin, MD 21811 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Ovanan Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed as the bunial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: nse 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 3 Ectopic pregnancy
 5 Other (specify) Year Pregnant at time of death Unknown g Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 5 Pending work' Natural Division 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within To the 29b. Signature and title of certifier

MGE(a.Si(clism)) 415/11 00066169 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 10445 Old Ocean City Blud #1, Berlin MD 21811 Mucela Gibbs, MD 2416 31. Date filed (Month, Day, Year) State 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2

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State of Maryland	Department of He	ealth and Mental	Hvaiene

		1- For State Certificate of Death Reg. No.														
Phy	sician		dle,Last)							2.	Date of D	eath			3. Time of Death	
Medical Ex	amine	Michael .	James H	Burns							Month April 10,	Day 2011	Yea	r	1125 hrs	
Service Mr.		4a. Facility Name (if not instituti 21448 Rodine Way			-	41	o. City, To Lexing						4c. County o			
	1												•			
Fund Direct		5. Social Security Number 225-04-6703	6. Sex	7. Age (In yr	rs. last birtl 51	hday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of 02/1			Foreig	thplace (State or nWashington	
	Towns of	Usual Residence of Decedent	,21,				I		<u> </u>	L	02/	.) / 1	700		DC	
	Å I	10a. State 10b. County		10c. C	ity, Town	or Locatio	n								10d. Inside City Limits	
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faryl	at o	10e. Street and Number										at Cour	ntry?			
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	otified at once		Way				20	653					US	A		
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Shoul N bind N	i i i	A CONTRACTOR OF THE PROPERTY O			0.00			•					City or Town	i, State,	Zip Code)	
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or le	F T	1 Burial 2 X Cremation	n 3 Removal fi			ory or othe		Or Cerrie	itery,		ale	1200	. Locadon -	City Oi	TOWIT, State	
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talt rmit.	jery	21. Signature of Funeral Service													ne, P.A.	
	9.5		Edward N. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval													
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Division of Vita To the Hospital or Attending Physicis	completely filled in by the funeral	(Check only	hysician: To the bes	of examination												
T wit	¥ S S	29b Signature and title of certific	and manner s	stated.			29c. L	icense n	number			29d.	Date signed	d (Mon	th, Day, Year)	
		1 Valula	2111					D.C.M.	E.			Ар	ril 11, 20	11		
		30 Name and address of person	who completed carry	se of death (its	em 23e\							1.				
6 REPRE			ssistant Medica			Penn S	Street, B	altimo	re, MD	21201						
6	State															
Re	gistra		2011	egistrar's Sign	p.)	PAU										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Elizabeth A. April Byron 9:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Montgomery Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 9. Birthplace (State or Foreign Country) NJ Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 □ XF Months Days Hours Dec. 24. 89 **Director** 150-14-6128 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 Yes 2 X No Silver Spring 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 1500 Casino Circle 20906 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White If Yes, Give Year or Dates "natural", 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked any injury or other traumatic every ပ Arthur Hervey Myer Edna Quackenbush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Elizabeth Byron/Daughter 1500 Casino Circle, Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licenses Francisc Addres Collins Funeral Home Inc. 00 University Blvd., W. Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Preumonia week disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical nding p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No ō Month Year Pregnant at time of death Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed atherosclerotic cardiovascular disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Addison's Disease ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? within 24 hours after deau.

To the Funeral Director. After this ce Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 10 D50534 homas Masters 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Masterson MD McLean VA ZZIOI 6858 Old Dominion Dr # 104

State Registrar 31. Date filed (Month. Day, Year,

11-02434 Edgile Belcher

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		- For State egistrar		Certific	ate or	Deaui			Reg. No.				
Physician Medical Examine	/ er	Decedent's Name (First, Middle, L Edgile	Belcher	Jr.				2. Date of De Month March 2	9, 2011	Year	3. Time of Death 1716 hrs		
	ľ	la. Facility Name (if not institution, g 9668 Baltimore Avenue	give street and number)		4	b. City, Town, or Laurel	Location of [Death		4c. County of Death Howard			
Funeral	1		Sex 7. Age	(In yrs. last bir	thday)	If Under 1 Yea				(MM/DD/YYYY) 9. Birthplace (State or Foreign			
Director		233-62-6476	X M 2 F	Min. 10/0	5/193	8 Col	untry) WV .						
b		Jsual Residence of Decedent		10c. City, Town	or Location	nn -					10d. Inside City Limits		
ow any		MD Howard	d		urel						1 Yes 2 No		
Aaryland 28a-f show 1 at once	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	f What Cour	itry?		
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Baltimore, MD 2' permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumaric	t	4 Donation 5 Other Specify: 21. Sign tur of Funeral Servic Vicensee PHILIP D.RINALDI FUNERAL SER 9241 Columbia Blvd.Silver Sp											
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Box 687 e death certific the attending j ed for use as t		past 12 months?	4 Pregnant at	time of death		her (Specify)							
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Div	Serti.	Suicide 6 Could not be determined (Specify) Home or Town, State) or Town, State) or Town, State) or Town, State) or Education of Town, State) or Town, State) or Town, State)											
	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day).												
	Mec	29b. Signature and title of certifier	and manner stated	·			se number				onth, Day, Year)		
3		and Co	DMI			0.0	.M.E.		March	30, 2011			
	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
Sta	ato	Russell Alexander MD. 31. Date filed (Month, Day, Year)	Looks III	ar's Signature	bar			,					
Regist		31. Date filed (Month, Day, Year)	U11 /2	. A.	BOU	4							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 31 Day Buck 2011 Carol Ann 7:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** District Heights Prince George's Forestville Health and Rehab 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland 1 🗆 M 2 🔀 F Months Days Hours 12/22/1934 Director 577-46-5910 76 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director Upper Marlboro MD Prince George's 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 14812 Chelsea Lane 20773 USA items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 ☐ Widowed 4 ☒ Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) with and Mental H William Francis Buck, Sr. Gladys I. Beck and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20773 P.O. Box 75, 14812 Chelsea Ln., Upper Marlboro, MD William F. Buck, Jr./Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ö injury (Metro Crematory 04/01/2011 Baltimore, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Arrhythmias disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the attending physician and thed for use as the burial-transit Cause (Disease or impury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month 5 Other (specify) Day Year Pregnant at time of death g Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pancreatic Mass 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗵 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X N 2 🗆 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 28a) (Type, Print) Kr Colony 1. dell 200

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

Division of Vital

Registrar's Signature

5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For AMEND#2 per PHY State of Maryland State of M Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3/26/201 3. Time of Death Physician/ OLANDER 2145 M DWIN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Min 1/28/1924 North Carolina Director 216-16-6139 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified. Annapolis 4 6 1 Maryland Anne Arundel 1

Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral Cheston Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 🗶 Yes 2 [If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify: 3 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Navy Chemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Louis Bolander Edith Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betsy Jenkins - Daughter 106 Conduit Street, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Norland Cemetery 4/4/2011 Chambersburg, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home Mydin What 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No signed by the a d be detached t 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 🗌 No 1 Tyes **Director:** After this certific in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 21 No Other: 1 Tyes P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
__1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury 2 Accident 3 Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours af

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HWY ANNAPULIS MOLIYOI AH N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

APR 0 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0645AM Richard Reynolds 20011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death <u>Meritus Medical Center</u> Washington <u>Hagerstown</u> 9. Birthplace (State or Foreign Country) Maryland If Under Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8 Date of Birth **Funeral** 1 XM 2 □ F Months 74 Jan:14,1937 Yrs Director 215-34-3759 Usual Residence of Decedent 28a-f show ortant. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Washington <u>Hagerstown</u> 10e. Street and Number 10g. Citizen of What Country? Funeral 13308 Marsh Pike 21742 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married XX Married 1 Yes If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ould be filed within 72 Ind Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales and Services 12 Owner Lawn and Garden Fouigment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lehman Martin Hilda Elizabeth Reynolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna J. Baer - Wife 13308 Marsh Pike Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ringgold Cemetery April 10,2011 Ringgold, Maryland 21. Signature of Funeral Service Licensee Osborne Tune Fally Home, P.A. 425 S. Conococheague St. Williamsport, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronany disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hyper Lipidenia 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Peripheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as s performed? Yes 2 XNo 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner. On the basis of examination and a monograph, many spanning of the firm, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 38471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jefferson Blvd. Smiths burg MD Kerns. 12H-6 22911

Registrar DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Alexander Barnard, Sr. March 20[°]1 7:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 911 Yardarm Lane Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Washington.DC 1 🕶 M 2 🗆 F Months Days 0*5*%14/1920 90 **Director** 579-05-1482 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 911 Yardarm Lane 21401 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Was Decedent Ever III 0.5.

Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1944–46 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Completed 3 ♥ Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cabinet Maker Woodworking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alexander Barnard Alice Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Barbara A. Gretz/Daughter 836 Southern Hills Drive, Arnold, Maryland 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State Maryland Veterans Cemetery | 04/06/2011 | Crownsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Augieral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home MALL 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ LLA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be det 23e. Did tobacco use contribute to the cause of death? δ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? ascu 25. Was case referred to medical 2 1 No 1 Yes 2 No Yes To the Hospital or Attending Physician: funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

Registrar

P.O.

Division of Vital

29b. Signature and title of certifier

10

Detense

of person who completed cause of death (Item 23a) (Type, Print)

116 Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

217965

29d. Date signed (Month. Dav. Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0341 Physician/ Month Bivens idnes James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner medical cente If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** Days Min. Months Hours 220-32-242 Director May maryland Usual Residence of Decedent , or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Princess 1 🗌 Yes 2 🔼 No Somerse Anne Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1853 Rd Back bone **Completed by Funeral** 12550 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 14 Yes 2 No
If Yes, Give 1959 - 1961
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔭 No Specify: Specify: Black 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Comercial Cleaning Sorvice 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Lena Bivens James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -Signer Blud. Princess Anne, md 21853 Beatrice 19657 Scotts wright 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) injury or -9-11 Princess Anne Md Mary's Cemeter 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Anthony E. any 30639 Md 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant a 9 Unknown Pregnant at time of death Other (specify) signed by the a 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director, After this certificate has been siy completed filled in by the funeral director, page 2 should to completed filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 욘 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 2

Registrar
DHMH 17 Rev 7/2009

State

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ March 31, 2011 Year Charles Brader 1:30 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery 6. Sex 1 ⅔ M 2 ☐ If Under 1 Year **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Months Days Director 011-26-1788 Nov. Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items be notified at injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 540 Southview Avenue of Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☒ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 🔀 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🍎 No Specify: Year or Dates 1956-58 Specify:White 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) USDA Federal Government <u>Director at</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elwood R. Brader Carrie L. Sell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brigid M. Brader/Wife 540 Southview Avenue, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 24X Cremation 3 ☐ Removal from State April 2011 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory of Funeral Service Licenses 22. Name and Address of Facility rancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final Malignant Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the dor use as the bunal-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed After this certificate 1 Yes 2 No ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b, Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director Algorithms for piece of the form of 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🔀 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 1)0055694 YSILIAD 31,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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31. Date filed (Month, Day, Year,

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Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Physician/ 2:20 Blough Imogene March Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Shady Grove Adventist Hospital Rockville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day Days 1 M 2 X F ^{Year)} 1927 Oct Pennsylvania 208-22-9240 83 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Germantown Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 Funeral "natural", or items 23a United States 20874 20422 Ambassador Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Black White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than any injury or other trainment. College (1-4 or 5+) Elementary/Seconday (0-12) Home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Garnet Thomas Allen Geist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20422 Ambassador Terrace, Germantown, MD 20874 Karen Beckwith/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 04/01/2011|Alexandria, VA 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee ME Millian MD 20877 MO1202 10 East Deer Park Dr., Gaithersburg, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Ph, sician/ Medical resulting in death) Due to (or as a consequence of **Examiner** Security list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of burialattending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial prompleted filled in by the funeral director, page 2 should be detached for use as the but completed filled in by the funeral director, page 2 should be detached for use as the but Box 68760 IF FFMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Year in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 I Inknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Other: 2 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check artitying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and to 120057574 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) 0 5 201

10301 Georgia Avenue, #203, Silver Spring, MD 20902 Ahmed Y. Heshmat, M.D., 32. Registrar's Signature

Inlogane

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3 Sally Ann Burnside Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WM Regional Medical Center Cumberland Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** WV Country) Months Days Hours Min (Month, Day, Y 75 **Director** 233-50-3266 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 72 hours after death with the Maryland Director WV Mineral Keyser 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 55 S. Main Street 26726 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+ Retail <u>Retail CLerk</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H

27 is marked of

traumatic ever Phillip B. Jordan Margaret Gift permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $144~\mathrm{D}$ $\mathsf{Street},$ $\mathsf{Keyser},$ WV 26726Edward Burnside/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 $\overline{\mathbf{X}}$ Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place) 4/15/11 Queens Point Cem 4 Dopation 5 Other (Specify) Keyser, WV uure of Funeral Service Licenses 22. Name and Address of Facility
Markwood Funeral Home, any in once. Inc. Nes 912 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiad or respiratory arrest, shock, or heart failure. List only one cause on each line. P 0 Box Keyser Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 000 6 disease or condition Medical resulting in death) or as a consequence of Examiner Nosze AL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine (or as a consequence of): OC To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi THOM WOOR OF ED BY MEDICA and Due to for as a c resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Vear Month Pregnant at time of death Unknown be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 H Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 [] No 1 Yes မ 1 Inpatient 2 LER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury work? 1 ☐ Yes 2 🛣 No s after death. 10:07 AM MOTOR Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) INTERSEC 8f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Southern SEK 5 milE Medical Certifying Physician: 76 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 🗌 Certiil only one 29b. Signature a nd title of co signed (Month, Day, Year) 201 Cumberla uite 670 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) and, 21502 MD 12502 Willowbrook Rd, Juan Arrisueon, MDSuite 31. Date filed (Month, Da Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 201^{Year} Month Physician/ April 1:20 a.M Milford Ray Cotton Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner St. Mary's Charlotte Hall Charlotte Hall Veterans Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Month, Day Year) 10/25/1928 North Carolina 1 🔀 M 2 🗆 F Director 82 240-38-2327 Usual Residence of Decedent IN INSTREE OTHER than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director 1 Yes 2 X No St. Mary's Mechanicsville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral with USA 20659 37989 New Market Turner Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 K Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Woodworking Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jenkins Rosa William С. Cotton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20659 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 37989 New Market Turner Rd., Mechanicsville, MD Vivian Cotton/Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Cheltenham, MD Maryland Veterans 4 ☐ Donation 5 ☐ Other (Specify) 04/14/2011 22. Name and Address of Facility Brinsfield-Echols 30195 Three Notch Signature of Funeral Service Licensee Funeral Home, I MD 20622 MOO817 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARRYTHMIA ARDIAC ⊋hysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HYPERTENSION SENTIA Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 1 Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav 2 No 9 Unknown P.0. n signed by ti 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has t autopsy performed? 1 Yes 2 No 25. Was case referred to ical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) ₩atural 5 Pending Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0067788 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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32. Registrar's Signature

29449 Charlotte Hall Rd., Charlotte Hall, MD 20622

DHMH 17 Rev 7/2009

Registrar

CHI CHEONG CHANG MANCH 31, 2011 2015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) March Physician/ 37 2019 2015 Chi Cheong Chang Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth Funeral Mau 04 Country) Months China Director 578-70-1751 Usual Residence of Decedent show 10d. Inside City Limits Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
permit. Page 1 halft and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County Director 1 Yes 2 X No Rockville Maruland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20850 U.S.A. 501 Hungerford Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify. Asian 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Self Employed Tailor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 501 Hungerford Drive, Rockville, Maryland 20850 Yu Liang Chang - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 04/09/2011 Silver Spring, Maryland 4 Donation 5 Other (Specify) Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 21. Signature of Funeral Service Li 11800 New Hampshire Ave., Silver Spring, MD 20904 M01621 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final cardia ₽nysician/ pulmonary disease or condition resulting in death) Medical Due to (or as a considence of): Examiner entic shock Sequentially list conditions. Examiner Due to (or as a sussequence of) cause. Enter Underlying Cause (Disease or linjury is chemic requires that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical leukemia P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) a \ Unknown the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Hospital or Attending Physician: The law autopsy performed' 1 Yes 2 No this certificate 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: After ompleted filled in by the fur 1 Yes 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D0065505 MID. April 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Rockvill+, 20850 990/ Medica cen MD Qui fang Chena 31. Date filed (Moh)h, Day, Year) 37. Registrar's Signature 0 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2011 Physician/ ARVOUM 8:35 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Brooke Grove Nursing Home Sandy Spring 8. Date of Birth June 24, 1909 If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Country) Greece 1 **⊠** M 2 □ F Months Days 101 Yrs Director 579-38-1125 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 No Glenwood Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21738 USA 15012 Rolling Hill Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. and Mental Hygiene. is marked other than "natural", or i Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Head Chef Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Athena Gianneotis Dionysios Karvounis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17709 Crystal Springs Terrace, Ashton, MD 20861 item 27 Dion Carvounis/Son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State April 2011 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death
MONTH Immediate Cause (Final Pnysician/ ONGGSTIV disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No the Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION, PROSTATE Division of Vital Records, HYPERTROPHY 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy this certificate has performed' death? 2 No Yes 2 N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Thursing Home 5 Residence 6 Other (Specify) 2 🗓 No Hospital 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c, License number 29b. Signature DO057630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anuvadha Arun MD SILVER 209 31. Date filed (Month, Day, Year, State

Registrar

APR 04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Carlos Physician/ R. Carrera March 30,2019 1455 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 D F 5907777928 °Ecuador 82 579-58-5941 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the M-dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 🗌 Yes 2 🔀 No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 8712 Colesville Road Apt.5 Ecquador hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married 1 XYes 2□No Specify Ecuadoran þ Maryland 21215-0036 White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) House Painter Paint Co. Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Obdulio Carrera Carlota Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eloy Carrera/Brother 1031 Margate Court Sterling, Virginia 20164 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Laurel, Md Maryland Nat.Mem 4/04/2011 5 Other (Specify) 21. Signature leral Service Li PHILIPADESRINALDI FUNERAL SERVICE, P.A. any 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician. segment elevation ST NOW myocardia disease or condition a Medical resulting in death) Due to (or as a consuluence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ı and al-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events renal disease Stace - dialysis Due to (or as a consequence of) resulting in death) Last burial physician a Physician/Medical Box 68760 attending p IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No ed by the a Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed this certificate 1 ☐ Yes 2 ☐ No Yes 2 ₩ 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Hospital Other: 2 1 No မ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 68005 March 2011 28 Briadis

State

Registrar

7600 Carroll Avenue, Takoma Park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Objecti

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31. Date filed (Month, Day, Year)

APR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2631 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Aqustina Cruz Caballero . 451 M Medical Facility Name (if not institution, give street and number, City Town, or Location of Death County of Death **Examiner** COMICO al 107 10 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 72 19977939 Mexico none **Director** Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director MD Wicomico Salisbury 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 207 Princetown Avenue 21804 Mexico 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 X Yes 2□No Specify: Mexican White If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 other than College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname)
Porfiria Caballero Santiago 17. Father's Name (First, Middle, Last) Agenit. Page 1 and 2 should be file bepartment of Health and Mental I important: If item 27 is marked of any injury or other traumatic eve any injury or other traumatic eve once. Andres Cruz Perez ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irenia Cruz/Daughter 207 Princetown Avenue Salisbury, Md. 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
Juchitan, Oaxaca, 4/872011 Cemeterio General e San Juan Del Rio 1 X Burial 2 Cremation 3 Removal from State Mexico 4 ☐ Donation ♠ ☐ Other (Specify) 21. Signature PHILIPADS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Meladola Priysician/ Melengac disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and I-trans Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year the signed by t d be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎾 Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 1 Yes 2 B B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Sother (Specify) H S ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural
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Suicide 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 327/11 0 63199 30. Name and accress of person who completed cause of death (Item 23a) (Type, Print) SALISBURY SHORE DA. 910 EASTERN YOGESHU VOHRA 31. Date filed (Month, Day, Year) State

Registrar

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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygewe. Int. If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once in other traumatic event, the Medical Examiner must be notified at once	۲	William L. Cull	er / Broth	er l	19882	Naples	Lake	s Ter	race Asl	nburn,	VA 20147	
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Box 68760, a death certificate be the attending physic ed for use as the bur	- 5 ∣	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outo	ome of pregnand	εy 2. Feta	у	Day	Year				
lox 6 eath cert e attendir for use a	<u>S</u>	past 12 months?		at time of death	-	er (Specify)						
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Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	<u>:</u>	27. Manner of Death	28a Date of In (Month, Day		b. Time of In	ijury 28c.	njury at Wor	k? 28	Bd. Describe how	w injury occurre	d	
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Division of Vital Records, P.O. Box 68760, In the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transit	Medical (sician: To the best of ner:On the basis of each	kamination and/o								
To To Com	Med	29b. Signature and title of certifier	and manner state	d		29c. Lic	ense numbe	r	2	29d Date signe	d (Month, Day, Yea	ar)
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		Name and address of person w	ho completed cause of	f death (Item 23a	a)							
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Registrar

State 31. Date filed (Month, Day, Year 2011 APR 0 1 2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e Per FH G914 4/25/2011 JH State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year Physician/ 2:30 pm Venus Howard Cooke March 30 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dove House Hospice Westminster Carrol Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. (Month, Day, Year) 2/16/1927 Director KY 294-20-559 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director MD Baltimore Hampstead 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA Church Road 21074 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian. 1. Marital Status 12. Was Decedent Ever in U.S. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: white 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) manufacturing secretarv Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Florence Robinson William Otis Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $80525\,$ 5300 Highcastle Court, Fort Collins, CO 19a. Informant's Name/Relationship (Type, Print) Jenine Stockdale, daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 X Removal from State Cooke Family Cem. 4/5/2011 Bakersville NC 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M00741 Eline Funeral Home 34 Hampstead, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in a condi-cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and dedetached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 1 No Yes 1 Yes 2 🗗 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) natrou Hospital: 2 🗖 No 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) e of certifier 29d. Date signed (Month, Day, Year) 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 Center St. Westminster. MD 21157 Flavio Kruter, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

			Ple	ase Type or Pr				-	_	e.					
			For State	State of M	laryland / Depa			<i>l</i> lental Hygi	iene	12634					
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	ith th	교	10e. Street and Number 30 Locust S	treet		10f. Zip Code	21157	11	-	g. Citizen of What Country? USA					
	ath w	nne	11. Marital Status	12. Was Decedent	Ever in IIS 13 V	Mas Decedent of L	lispanic Origin? (Spe		nerican Indian,						
9	or its	λF	1 Never Married 2 M	Armed Forces?	-No	f Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Wh						
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lan	be fil entat rked ic ev	ပ	James J. O	nelly											
Maryland	nould Ind M s mai		19a. Informant's Name/Relation		19b. Mailir	ng Address (Street			City or Town, State,	Zip Code)					
	d 2 sl alth a n 27 is ertra	100	Fay Glass,	daughter		-			vn, MD 2						
ore	of He of He fiten		20a. Method of Disposition 1	2 Demonstra	20b. Place of Dispo	sition (Name of natory or other plac	ce)	Date 2	20c. Location - City	or Town, State					
Ĕ	Page ment ant: I ury o		4 Donation 5 Other				Eion $4/1$	/2011	Hampste	ad, MD					
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show way injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee MC	0741	. Name and Addre	ss of Facility $ {f E}]$	line Fu	neral Ho	ome					
	σ□ <u>=</u> α ο		Standa /	Lemme					mpstead,	MD 21074					
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-	Physician/ Medical	1	disease or condition resulting in death)	a		Lung	(sucer			Unset and Death					
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tal	sician: The law i certificate has b lirector, page 2 s	Be	25. Was case referred to medica examiner?	Hospital:		T	ace of Death (Check	only one)		10					
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Division of Vital Records,	tal or s afte al Dir		/	building, et	c. (Specify)			City or Town,	State)						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, Fifter this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifyir (Check 2 Medical	g Physician: To the best of	my knowledge, death o	occured at the time	, date and place, an	d due to the cause	e(s) and manner as s	stated. e cause(s) and manner stated.					
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	9		30. Name and address of basic	24 W Z 75	SPNEL A	. 5 U	7e 307	MEON	msper r	10 21/57					
	Sta	.6	31. Date filed (Month, Day, Year)		ar's Signature				1						
	Registra	ar	APK U	4 2011 Sens	un B. A	arke									

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		- For State Certificate legistrar	of Death	Reg. N	0.							
Physiciar Medical Examin	1/	1. Oecedent's Name (First, Middle,Last) Trevase J. Chew		Date of Death Month Day April 8, 2011		3. Time of Death 1248 hrs						
PAGICAL EXAMINA		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Oeath		4c. County of Death							
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Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 216-47-8127 1	Foreign									
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D & A A A . S	1	23a. Part I. Enter the disease, or complications that the used the death. Do not enter	r the mode of dying, such as cardiac o	r respiratory arrest, s	hock, or heart	Approximate Interval Between Onset and						
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Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been s led in by the funeral director, page 2 should death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	reet, factory, office building, etc.	28f. Location (Stree or Town, State)		ral Route Number, City						
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		Ml brasse U Mit	O.C.M.E.	A	pril 9, 2011							
		 Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 	Penn Street, Baltimore, MD	21201								
Sta Registr	~	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ranks									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0155 AM James F. 2011 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours (Month, Day, Year) May 5, 1938 1 2 M 2 🗆 F MD 72 Yrs **Director** 216-36-5611 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔼 No Prince Frederick MD Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 3 Funeral with USA 20678 346 Fairground Road items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 9 Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: than "natural", 3 Divorced 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Home Improvement **Painter** marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Hattie Viola King James Thomas Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra 651 Lakeway Drive, West Babylon, NY 11704 James F. Campbell Jr. - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory April 4, 2011 Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. Signature of Funeral Service Licensee 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE rate has been signed by the attendin page 2 should be detached for use 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 🗌 No 1 🗌 Yes this certificate Yes director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 🗷 No 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 27, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No (Month, Day, Year) injury 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) D chang 01 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

1020 MARUT 30, 20/11 #ELEN CRUMP MARLY Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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ital or urs afte ral Dir led in		i.			bullal	ng, etc	. (Specify,) 					- 8	, '	City or To	vn, Sta	te)			
To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this ce completed filled in by the funeral director.	Medical	(Check 2		xaminer	r: On the bas	is of ex	amination	and/or i	nvestiga	ation, in	my opinio	n, death	occurred a	at the ti	me, date a	and plac	ce, and due	to the ca	use(s) and manner sta	ted.
Fo the vithin Fo the somple		only one) 3 29b. Signature and t	Certifying itle of certifier	Nurse F	ractioner:	lo the l	oest of my	knowled	lge, dea		License			ice, and	due to tr		e(s) and ma ate signed			_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}011 Physician/ WILLIAM В. COLLINS, SR. 5:30 A M April 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Tate House Linthicum Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 91 Yrs. **Funeral** Days Hours Min. 561-54-0866 1 **X**] M 2 □ F Ju1930 1919 Oneida, NewYork **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Prince George's Bowie 1X Yes 2 ☐ No 10f. Zip Code 20716 10e. Street and Numbe 10g. Citizen of What Country? United States 17121 Russet Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give 10/10—106 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 72 hours after White 1 ☐ Yes 2 X No Specify. "natural". If Yes, Give 1940-1967 Specify 3 V Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ould be filed within 72 Ind Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft Mechanic U.S. Marines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Palmer Clinton Benton Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . 22 permit. Page 1 and 2 sh
Department of Health as
Important. If item 27 is
any injury or other tra Ruth C. Matthews -daughter 17121 Russet Drive Bowie, Maryland 20716 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 4/1/2011 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Donald V. Borgwardt Funeral Home, PA Danal 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cardiomyopathy disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to für as a consequence on if any, leading to immediate cause. Enter Underlying Examir the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No g Unknown 9 Unknown þ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown has been sig e 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy performed? Yes 2 X No page death? certificate ! 1 Yes 2 No Yes : After this certifical tuneral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?

1 Yes 2 XNo Hospital 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice care ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? injury 5 Pending within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 29c 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Russell R. DeLuca, M.D. 305 Hospital Drive Glen Burnie, Maryland 21067 31. Date filed (Month, Day, Yea. State APR 05 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 11, Day Physician/ Aprit 2011^{ear} 6:45 John Patrick Crosby Jr. AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Tranquillity at Fredericktowne Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Year 1928 Washington DC Months Days Hours Min Oct. 31 578-34-9213 82 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d Inside City Limits Director 1 X Yes 2 ☐ No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21703 United States 186 Allesandra Drive death 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No
If Yes, Give 1057 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married <u>۾</u> Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 XNo Specify Specify: White "natural", Year or Dates. 1957 Completed 3 Widowed 4 Divorced other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) rould be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Law Enforcement Dispatcher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gladys Louise Moser John Patrick Crosby Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 6437 South Clifton Rd., Frederick, MD 21703 Kathy Fisher (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 4/13/2011 Smithsburg, Maryland Signature of Funeral Service Licensee Keeney & Basford P.A. Funeral Home MO1612 106 E. Church St., Frederick, 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final COTONGIY Ph sician/ disease or condition Medical resulting in death) Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events asthma Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Vear 4 Pregnant at time of death 9 Unknown 2 □ No 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy performed? Yes 2 No death? certificate l 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No 1 Yes fo the Hosping...
Within 24 hours after death.

To the Funeral Officer After this of the Funeral Officer after this of the Funeral officer after the funeral direction. မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 \(\sum \) Yes 2 \(\sum \) No injury 1 Matural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 1) 36 421 2011 and address of person who completed cause of death Frederick MD 21701 9093 merena

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DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Gopies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ or Location of Death 2011 10:50 A M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Examiner Prince For Hen Kehal NAShina ton If Under 24 Hrs. B. Date of Birth 9. Birthplace State or Foreign Social Security Number 6. Sex 1 ☐ M 2 ☐ F . Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Min. 1 1 - 2 4 -Maryland Months Hours 54 **Director** 215-70-7914 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Directo 1X Yes 2 ☐ No Maryland Brandywine Charles 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 20613 3998 Turner Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 XNever Married 2 Married <u>۾</u> Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "1 Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Self-Employed 12 injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Henson Mamie Albert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or or 5117 Suitland Rd Apt202, Suitland MD 20746 Doris Brown/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Dremation 3 Removal from State 4 - 10 - 11Alexandria, Va 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan 21. Signature of Funeral Service Lio nsee 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco Md, 20608 Earl T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death OBSTRUCTION Lun Immediate Cause (Final Or Sears CHamie Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending howards. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 1 Yes 2 9 Unknown 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ►No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗌 No 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c, License number D35206 1 aunent 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Guingsten Rond, Ft. WASHington 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 4 Daniel Lewis Donaldson 2011 Medical 10:15 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2809 Shiloh Church Road Bryans Road Charles . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ▼M 2 □ F Days Months Hours Min. (Month. Day, Year, 81 042-22-9755 Director 18. 1929 Washington D.C. Tune Usual Residence of Decedent 28a-f shov at 10a, State 10b. County should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 🗌 Yes 2 💢 No Maryland Charles Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20616 U.S.A. 2809 Shiloh Church Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married 2 No 1946-Yes f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Divorced Specify: Completed 1947 White Year or Dates 27 is marked other than "naturate traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than College (1-4 or 5+) Truck Driver Food Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edythe Lewis George Donaldson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2809 Shiloh Church Rd., Bryans Road, Md. 20616 Brian M. Donaldson Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) April 7, 2011

Metropolitan Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State ± 5 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: It any injury or Alexandria, Virginia 21. Signature of Funeral Service Lice Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, 20640 Part 1. Enter the shock, or heart disease, or complications that carailure. List only one cause on eac ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final al anoma Physician/ mal disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy þ in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death 1 Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò page 2 should be 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Besidence 6 ☐ Other (Specify) the funeral 27. Manper of Death 28a. Date of injury 28h. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Eertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRIL 2011 **Physician** 3:16 AM ALICE ELIZABETH DORSEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CHARLES WALDORF RESIDENCE. 11423 WILDMEADOWS STREET If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** · 1930 MARYLAND Months OCTOBER 24 1 □ M 2 🙀 F 80 218-28-5709 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Ito Medical Examinat must be notified at 1 Yes 2 No Director WALDORF CHARLES MARYLAND with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 20601 11423 WILDMEADOWS STREET Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 Å If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within ind Mental Hygiene. Secondary (0-12) College (1-4or 5+) PRIVATE HOUSEKEEPER 7TH GRADE should be file alth and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DOROTHY CECELIA JOHNSON DORSEY JAMES BERNARD DORSEY ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health at Important: If item 27 is any Injury or other trau 11423 WILDMEADOWS STREET, WALDORF, MARYLAND 20601 LINDA M. DUNBAR / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ST. MARY'S CHURCH CEMETERY APRIL 11,2011 NEWPORT, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Size ature of Funeral Service Licenses 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MOO583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ~ce Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed and the burial-tran Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 Unknown 9 🗆 Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 3 → robably 4 □ Unknown 1 ☐ Yes 2 ☐ No cate has been signated by page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only on) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Hospital or Attendi 24 hours after death, Funeral Director: 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 24 hours a 29a, Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

St

State Registrar

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Saw

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 201T Faye Glennie Dooley 2:23 p. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 09/09/1922 Months Hours 88 231-38-5540 Florida Director Usual Residence of Decedent or 28a-f show a notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Examiner must be Funeral with items 23a 20<u>636</u> 24770 Cougar Court USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify "natural", 3 X Widowed 4 ☐ Divorced Completed White f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 7th Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Harry Beeder Faye Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24770 Cougar Ct., Hollywood, MD 20636 Dana M. Wolfe/Granddaughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 04-14-2011 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Cemetery Jacksonville, FL 21. Signatur neral Structure Lawrence N. Bringfield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Atherosclerotic Cardiovascular Disease Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transit Physician; The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 4 Pregnant a 9 Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 within 24 hours arer death.

To the Funeral Director. After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Disease 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending 5 Pending X Natural 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 retifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

William D. Boyd, II

APR 12

31. Date filed (Month, Day, Year)

D14285

25365 Point Lookout Rd., Leonardtown, MD 20650

04/05/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year MARCH 2011 GAIL ELLEN DIAMOND Medical 7:13P 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) NEW YORK Social Security Number Funeral Days 1 □ M 2X F Months Hours Yrs Director 213-66-1511 57 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MARYLAND ANNE ARUNDEL MILLERSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8388 SCARLET GLEN CT 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DENTAL HYGIENIST DENTRISTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic WARREN BALLENBERGER DOROTHY COFFILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD SCOTT DIAMOND/HUSBAND 8388 SCARLET GLEN CT, MILLERSVILLE, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place ESTGATE MEMORIAL ARK 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ANNAPOLIS 04/09/2011 22. Name and Address of Facility LASTING THELFENBEIN & NEWNAM CREMA P.A. 814 BESTGATE ROAD, A Signature Funeral Service Live Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ la disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician by Physician/Medical P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed plnods within 24 hours after death.

To the Funeral Director: After this certificate has been completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 5: autopsy performed? 1 Yes 2 No Yes 2 - No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar Parkway

Str 210 Annapolis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
APR 0 5 2011

003

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 24, 2011 Year Herbert Paul Diehl Sr. 08:55 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western Maryland Regional Medical Center Cumberland Social Security Number g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral 7. Age (In vrs. last birthday Days 1 M 2 - F 215-34-4788 78 December 17, 1932 Maryland Director Usual Residence of Decedent 28a-f show 10b. Count 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Examiner must be notified at Director Mount Savage Allegany 1 Yes 2 No Maryland 6 10e, Street and Number 14129 Lower Sunnyside Road 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. or items 23a 21545within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 □ No
If Yes, Give
Year or Dates. Black White etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: "natural", White Completed 3 X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Ort's Inc Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lula Ann Michaels John F. Diehl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21545-12801 New Row Road N.W. Mount Savage Maryland Tracev King daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Restlawn Memorial Gardens any injury or Maryland LaVale March 28, 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final while Priysician/ disease or condition resulting in death) n Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Harm lower cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No been signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate has 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation. Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 2 30. Name and address of person who completed eause of death (Item 23a) (Type, Print) mn nds

State Registrar 32. Registrar Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Richard Deremer Month Robert 9:05 Α April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Flintstone 14400 Pleasant Valley Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1249474924 Maryland 86 218-16-2702 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Flintstone MD Allegany 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21530 14400 Pleasant Valley Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Logging Logger Be 18. Mother's Name (First, Middle, Maiden Surname) Edna Ruth Fisher 17. Father's Name (First, Middle, Last) Edna Ruth ၉ Deremer Marshall Issac 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 615 Beans Cove Road, Clearville, PA 15535 Cheryl Resh / Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 KD Burial 2 Cremation 3 Removal from State Prosperity UMC Cemetery 04/05/2011 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, Signature of Funeral Service Li 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Covonan Physician/ disease or condition resulting in death) Medical Due to (or as a consequence θ f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be s. 24 hours after death.

Funeral Director: After this certificate has been sinned by the attending about the stranding about 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Kes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 🗆 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examines. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 4, 2011 D33280 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil K. Gupta, M.D., 625 Kent Avenue, Cumberland, MD 31. Date filed (Month, Day, Year) Registrar's Signature APR 0 4

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State/MEND#26+29open/ND,4/5/11;EMW,Moo Contificate of Death Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March Physician/ 31 2011 9:55 P M Margaret L. Donahue Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 404 Charlotte Court Berlin Worcester Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthday) Days 1 □ M 2√2 Hours 577-32-1849 19/ **Director** 85 Washington DC Usual Residence of Decedent items 23a or 28a-f show her must be notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Batt. If fiew 27,5 is marked of the than "natural", or items 23a or 28a-f sho land to other traumatic event, the Medical Examinar must be notified at inny or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4620 Cherry Valley Dr. <u> 20853</u> USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 XWidowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of wark dane during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government rector of <u>Acquisitions</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Mahaney Margaret Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other t Kathleen Dixon / Daughter 2012 Carter Mill Way Brookeville, MD 20833 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Wash. Cem. 4/4/2011 Adelphi, MD 22. Name and Address of Facility Francis J. Collins Funeral Home, Signature of Funeral Service Licenses 500 University Blvd., West, Silver Spring, MD 20901 MO1503 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to jor as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last TOO II Do Hospital or Attending Physician: The law requires that the death certificate be executed an Due to (or as a consequence of): burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy For in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) Pregnant at time of death be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate 2 🗆 No Yes 2 No 1 🗌 Yes pleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital daughter's residence 2 No Other: 은 1 Tyes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending work s after death. 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical **Medical Examiner:** On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of certifier 29c. License number **D**-68067 10 CNCIFED 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10445 Old OceanCit 31. Date filed (Month, Day, Year) Registrar's Signature APR 05 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 11:37P. M 2. Date of Death 7, Da 2011 Year Yasmin Aphril Physician/ Brita Durrani Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 17513 LaFayette Drive Montgomery Olney Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 585-12-3383 Months Days Hours Min March 22 1936 Finland Director Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location other traumatic event, the Medical Examiner must be notified at Director Maryland Montgomery Olney 1 🗆 Yes 2 🔀 No 28a-f 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral items 23a 20832 United States 17513 LaFavette Drive filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc.
White ò þ 1 Never Married 2 X Married 2 💢 No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify "natural", 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Transportation Elementary/Seconday (0-12) Staff Assistant Workers Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rauha Juntilla Sigurd Portin permit. Page 1 and 2 should be Department of Health and Ment Important; if item 27 is marke any injury or other traumatic to 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17513 LaFayette Drive Olney, Maryland 20832 Sajjad H. Durrani -husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Fort Lincoln Cemetery 4/8/2011 1X Burial 2 Cremation 3 Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Malad VireBorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Amyotrophic Lateral Sclerosis months disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam the Hospital or Attending Physician: The law requires that the death certificate be executed and I-trans resulting in death) Last Due to (or as a consequence of): physician a sthe burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 XNo Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) Year Month Day Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 2 XNo ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 **X**No ဂ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗡 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred <u>ë</u> injury 5 Pending work Certifical death. 1 Yes 2 No Accident Investigation Director: A 6 Could not be Suicide hin 24 hours after de the Funeral Directo mpleted filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

29a. Certifier (Check

only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

well

Morris

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registra 's Signature

Bennett Morrison, M.D. 2901 Olney Sandy Spring Road Olney, Maryland 20832

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D47682

29d. Date signed (Month, Day, Year)

April 8, 2011

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 20^{Year}1 CHARLES DYSON SR. REGINALD 11:45PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESAPEAKE SHORES NURSING HOME LEXINGTON PARK ST. MARY'S If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 1X M 2 | F Days Hours 214-28-4522 Country)
MARYLAND Director 82 1928 Usual Residence of Decedent or 28a-f show 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD CHARLES HUGHESVILLE 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8328 OLD LEONARDTOWN ROAD 20637 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married XXMarried 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: 3 Widowed 4 Divorced Specify: WHITE Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 Ith and Mental Hygiene. 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) CHIEF LINEMAN ELECTRIC COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE CONRAL DYSON ELIZABETH BOWIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau MARY ELSIE DYSON/SPOUSE 8328 OLD LEONARDTOWN RD., HUGHESVILLE, MD20637 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State APRIL 1X Burial 2 Cremation 3 Removal from State ST.MARY'S CH.CEM. 19, 2011 4 Donation 5 Other (Specify) BRYANTOWN, 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licer 13 M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one call on each line Immediate Cause (Final Physician/ disease or condition resulting in death)) Medical Examiner Sequentially list conditions, if any, reading to minimistrate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events Due to resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Pregnant at time of death 2 🗌 No the Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1
Yes 2 Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? iniury 5 Pending 2 🗌 No ☐ Accident ☐ Suicide Investigation Director: / 6 Could not be 3 within 24 hours after de To the Funeral Directo completed filled in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date si ned (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALIKHANI, M.D. 101 CENTENNIAL AVE., LA PLATA, MD 31. Date filed (Month, Day, Year) \$2. Registrar's Signature September . Registrar

A.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 March 29, Physician/ 10:36 A M Medical institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Days Hours Min. Country) 1 □ M 2 💢 09-07-1926 CA Director 572-24-5365 84 Usual Residence of Decedent shov 10a, State 10b. County 10d. Inside City Limits with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Tes 2 X No MD Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20688 United States 11450 Asbury Circle, Apt. 226 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any Injury or other traumatic event, the Medical Examiner musonce. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 1 Never Married 2 Married ፩ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Writer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jeanette Gordon Unattainable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5714 Kneeland Lane, Tampa, FL 33627 Mark Erickson - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Middleham Chapel Cem. 04/08/2011 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lusby, Maryland 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician disease or condition resulting in death) 10 Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Exami attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No signed by the atte Month Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANTENS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? certificate Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lawrence R. Kelley, MD 7901 Maple Ave., Takoma Park, Maryland 20912 31. Date filed (Month, Day, Year, 32. Registra Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 00:221 CHARLIE **BRANFORD** 2011 **EVANS** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edional Medical 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Months Days Hours 10/07/1943 Mary Land 219-44-1206 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene.
Important: If item 27 is marked of ther than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Somerset Ewell 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20803 Caleb Jones Road 21824 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Owner General Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leroy Evans Gertrude Brimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charli D. Evans (Daughter) 26654 Old State Road - Crisfield, MD 21817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Crematory of Delmarva 04/05/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Lungral Service Libensee
Robert H. Bradshaw Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ COPD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): -transit Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ASUD Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should by 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending Natural
Accident
Suicide injury work? 5 Pending 2 🗆 No Investigation the Funeral Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29c. License number 29d. Date signed (Month. Day, Year) 63199 4/4/11

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

Registrar

31. Date filed (Month, Day, Year)

YOGESH

32. Registrar's Signature

910 GASTERN

address of person who completed cause of death (Item 23a) (Type, Print)

D.R

SA LISBURY

21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 20 jai 4:35 PM Katherine Fayrene Frazier Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
December 21, 1945 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 E Hours Months 213-44-6186 Director Yrs. Maryland 65 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Maryland St. Mary's Leonardtown 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 40338 Breton Beach Road 20650 USA 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 🗷 Widowed 4 🗌 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event than Financial Manager United States Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ James Virgil Mattingly, Sr. Favrene Hallmark 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracey Michelle Mattingly P.O. box 958 Leonardtown, MD 20650 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory April 15, 2011 Alexandria, Virginia Sion fure of Funeral Service Lice 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ KESPIRATORY WEEKS disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 🔀 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PULMONTRY CARDUIC OBSTRUCTIVE 2 No 3 Probably 4 Unknown Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) in 24 hours after deaur. he Funeral Director: After this ce noleted filled in by the funeral dire Hospital: 1 ☐ Yes 2 No Other: |은 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. APRIL 12,2011 #5 eme Name and address of person who completed cause of death (trem 23a) (Type, Print) LEONARDTOWN, MARYLAND 20650 ST. MARY'S LAOSPITAL ATRICIA GURM 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Eva April Fuechsel 2011 a^{M} 3:20 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince George's 5. Social Security Numbe Birthplace (State or Foreign Country)
 Germany 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Feb. 23 1 M 2 XF Months Days Hours Min. 268-30-2080 92 **Director** 1919 Usual Residence of Decedent should be filed within 72 nouro and and Mental Hygiene.

7 is marked other than "natural", or items 23a or 28a-f show the marked other than "natural", or items 25a or 28a-f show the marker than "marker ovent, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3122 Gracefield Road, #T19 20904 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married Maryland 21215-0036 Specify:White 1 ☐ Yes 2 No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4-or 5+) Elementary/Seconday (0-12) Cafeteria Manager School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Georg Adelberger Pauline Renneis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter G. Fuechsel/Son 13906 Castlebar Drive, Glenwood, MD 21738 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
letropolitan Crematory 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State April 13 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 500 University Blvd.. Silver Spring.MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Dun to (or es a nonsequence of) use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attendion above. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death Month Day signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Chronic Kidney Disease, Parkinson's Disease, Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Myelofibrosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 🔀 No 1 ☐ Yes 2 ☐ No Yes of Vital cempleted filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury work? Division 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) 0

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

APR 04 2011

Name and address of person who completed cause of death (Item 23a) (Type, Print) Arleen Allen, MD 7300 Van Dusen Road, Laurel, MD 20707

11-02737 Brian Heath Frazier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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1		Come	100		6

		1- For State Registrar			Certific	cate of	Death			I	Reg. No.			
Physicia	n/	1. Decedent's Name (First, Midd	Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year								r	3. Time of Death		
Medical Examin	1er	Brian Heath F				- 1.				April 9, 2	011			1450 hrs
		4a. Facility Name (if not institution, give street and number) 888 Rockville Park 4b. City, Town, or Location of Death Rockville										. County of nontgon		
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last bi	rthday)	If Under 1 Year Months Days		Min				Foreign	hplace (State or
Director		577-96-3660	1XM 2_F	4.	4	Yrs.	World S Day	- Hours		SEP 1	0, 1	966	Cou	intry) MD
any	1	Usual Residence of Decedent 10a. State 10b. County		110c	. City, Towr	n or Locatio	on						- 1	10d. Inside City Limits
. .			gomery	1	ockvi		 V							1 Yes 2 No
Maryland 28a-f show	횽	10e. Street and Number			OCK VI	116	10f. Zip Code		4		10g. Citiz	zen of Wh	at Coun	try?
the N	1 Director	13006 Payson	Street				20853	3			Uni	ted S	Stat	es
th wit	Funeral	11. Marital Status 1 Never Married 2 M	12. Was Dec		r in U.S.		Decedent of His s, specify Cuban				0-	14. Race White		can Indian, Black,
ter dea			1 Yes	2 X	No	1 1	Yes 2 X No	specify:				Specify:	Cau	casian
11215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner	음	15. Decedent's Education (Spe	or Dates:		ed) 16a.	. Decedent	s Usual Dccupat	ion (Give k				(ind of Bus	siness/Ir	ndustry
72 ho	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)		during mo	st of working life.	DO NOT	use retired	1)				
215-0036 be filed within 77 ntal Hygiene. rked other than ent, the Medical	티	12			(Carpe						1f Er	np1o	yed
15-003 filed within Hygiene. d other th		17. Father's Name (First, Middle, Richard Gail								irst, Middle,	Maiden	Surname)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than market, the Medica	To Be	19a. Informant's Name/Relations			19	b Mailing	Address (Stree			Yates	mber Ci	ty or Towi	State	Zin Code)
MD 21 td 2 should lith and Me 27 is ma	-	Mary Ann Fraz		er		-	Payson					•		
	-	20a. Method of Disposition	- [V]		20b. Place		ion (Name of cen			ate				Town, State
imore, MD 2 Pages 1 and 2 shoul ment of Health and N tatent If item 27 is n or other traumatic.		1 XBurial 2 Cremation 4 Donation 5 Other Sp		om State	Pleas	sant	View M.C	;.	04/14	4/2011	Kea	ırney	svi	lle, WV
Baltimore, permit. Pages 1 an Department of Hea Important: If itee	Ì	21. Signature of Funeral Service Licensee MO0056 Zhame and Address of Facility Thibadeau Mortuary Service, p.a.												
	-1	23a. Part I. Enter the disease, or	complications that ca				Park Ave							Approximate Interval
Physician Madical	-	failure. List only one cause	on each line.				, .			opii atory a	, 500, 6116	o., o. 1100		Between Onset and Death
xaminer	-	Immediate Cause (Final disease or condition resulting in death)	a. Alcoho Due to (or as a			ation	and coc	aine	use					
	J	Sequentially list conditions,	b											
` .	흴	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	conseque	nce of):									
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1760, ficate be ex g physician the burial	ĕ	IF FEMALE:	23c. If yes, o	outcome of	pregnancy	,					230	l. Date of	delivery	
		3b, Was decedent pregnant in the past 12 months?	1 Live b	irth ant at time	- f -1 11-		il death 3	Ectopic	pregnancy	/	1	Month	D	ay Year
Box 68 e death certificate the attending ed for use as it	Physician	1 Yes 2 No 9 Uni	known 9 Unkno			5 Oth	er (Specify)							
at the		Part II. Other significant condit	ions contributing to	death but	not resultir	ng in the un	derlying cause g	iven in Par	t I.	23e. Did	tobacco i	use contril	oute to t	he cause of death?
ires that signed to be deta	d b	Cirrhosis of	the liver			<u> </u>		<u></u>		1 Ye	es 2]No 3[Proba	ably 4 🗹 Unknown
ords, w requires been should	Completed									24a. Was				opsy findings available ompletion of cause of
he law	E									perf	ormed?) d	eath? ✔ Yes	2 No
tal Rec	0	25. Was case referred to medical							Check only	y one)				
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ding Ph.		27. Manner of Death 1 Natural 5 Penc		of Injury Day,Year)		Time of Inj 2:40		y at Work?		d. Describe	how inju	ry occurre	ed	!
Attence or death	ğ	Pend	stigation Id 4-		£d	2:56	pm	es 2 X	[U1	nknow		- d Ni l -		al Day to Number Cit
Division of Vital Records, P.O. as or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detacted.	Certification:	3 Suicide 6 X Coulded	a not be				factory, office bu		- 1	or Town,	State) Q	88 Ro	ckv	al Route Number, City ille Park
Hospit Tunera		4 Homicide 29a. Certifier 1 Certifying Pt	nysician: To the best				nind a s			OCKVI	LIE	MU.		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		(und	miner:On the basis of and manner st	f examinat	-									
F. 2 F. 8	Ž	29b. Signature and title of certifie		arou.			29c. License	number			29d. [ate signe	d (Mon	th, Day, Year)
1-PÉND		D-~					O.C.N	∕ I.E.			Apri	l 10, 20	11	
*	ŀ	30. Name and address of person					2	D - !!!		04004	1			
		Donna M. Vincenti, MI		ledical E gistrar's Si			Penn Street,	Baltimo	re, MD 2	Z1201				
Sta Registra		31. Date filed (Month, Day, Year) APR 13 2		giou al S Ol	J. A	back								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 0^{Day} 2011 Sibley Raechel Fuller 10:17 a^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9th Street Calvert North Beach 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Hours Min. 1 M 2 X F 09/05/1939 **Director** 516-42-3831 MT Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No MD Calvert North Beach 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 4100 9th Street 20714 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 🗆 Widowed 4 🗆 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) National Association of Elementary/Seconday (0-12) College (1-4 or 5+) Executive Legislative Assistant Letter Carriers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harold V. Redding Winifred Montana Sibley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph B. Fuller / Husband O Box 1154, North Beach, MD 20714 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 04/07/2011 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. J. Coff Gary 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): nding physician use as the burial Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? been signed by the atte should be detached for Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 2 🗆 N Yes the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 잍 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred work? 1 Natural 5 Pending injury s after death. 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Frantioner To the best of my knowledge, do 29b. Signature 29d. Date signed (Month, Day, Year) 201 (of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

APR 06

Box 68760

P.O.

Division of Vital

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Dav Year 1612 PM Luder MH 01 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick Calvert Calvert Memorial Hospital 8. Date of Birth (Month, Day, Year) 3 / 29 / 1933 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 1 □ M 2 🛛 F 78 Director 225-44-2161 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at rector 28a-f Huntingtown Calvert MD 1 X Yes 2 No â or. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20639 USA 4180 Robinson Road "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. hours after þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: If Yes Give 3 X Widowed 4 □ Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 18b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ Goldie May Overhulser should be Sandy Jackson Plogger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a 4210 Robinson Rd. Huntingtown, MD 20639 Howard Fluty, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State Donation 5 Other (Specify) Mem'l Gdns 4/6/2011 Dunkirk, MD Signature of Euroral Service Licenses 22. Name and Address of Facility Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, MD 20754 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Advance of Neels Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical attending p as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death signed by the a d be detached f 1 Yes 2 × 9 Unknown 9 Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 N certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury 28b Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2006178 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pr. Frederick LRW R.L. Hospita Choi 100 Chana 31. Date filed (Month, Day, Year) 32. Registraris Signature State

Registrar

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 Day Physician/ April 20ÎÎ 2025 Рм Paul Russell Fish, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b, City, Town, or Location of Death Ceci1 Union Hospital E1kton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral JAN 14, Year) 927 Days 1 X M 2 □ F Yrs Pennsylvania Director 220-12-5057 84 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No Florida 0sceola Saint Cloud 5 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 605 Jersey Avenue 34769 United States items 12. Was Decedent Ever in U.S. Armed Forces? WOTId 1 2 Yes 2 4 No If Yes, Give War II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner or i Black, White, etc ^{2□} War II Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: Specify: White and Mental Hygiene. is marked other than "natural", 3 X Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry Veterans Administration 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) rie Da Notuse retired Ssistant Director of Olunteer Services Elementary/Seconday (0-12) College (1-4 or 5+) Hospita1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Paul Russell Fish, Sr. Lena Mav Walk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health s Ronald Scott Fish/Son Sandhurst Lane, Elkton, MD 21921 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or other cemetery, crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) R. A. Ferris & Co., Inc. West Chester, PA 2011 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licenses 21921 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kulmonary Disease Physician/ ueans disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on and -transit that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-t Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No 1 Tes 2 L 9 Unknown been signed by the should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was ... autopsy performed? this certificate has 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🗹 No Hospital Other: ဂ္ 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending | 24 hours after death. Funeral Director: After (Month, Day, Year) Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3+1VA

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print S. SHCHDEV MD , 126A, E 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Jackden-S. MD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Do023322

h ST, Elkten MD 21921.

4.5.2011.

To the F

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Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item# 5, per fh, 9915 5-19-11 sm State of Maryland 7 Department of Health and Mental Hygiene 0 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Donald Ganley 2011 2:55 amm April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Gaithersburg 5. **249.534147912** 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year _ If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Year 1930 Min April 8, 1XXM2∏F Hours 80 **Director** 219-48-7912 Maryland Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Frederick **Ijamsville** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10037 Doctor Perry Road 21754 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 A No Specify: white Specify 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Concrete Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Mackin Ganley Nettie Swartzbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10037 Doctor Perry Road, Ijamsville, Maryland permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Arlene Ganley - wife 21754 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial 4-5-2011 Frederick, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home elene 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ NON Ma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any less ing to in a class cause. Enter Underlying Due to (or as a nonsequence of) Exami Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death Day signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ► Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛎 Natural 5 \square Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопрете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) oseph M. Haggerter D32407 April 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 9707 Medical Center Drive, Rockville, Maryland 10+1VA Joseph M. Haggerty, MD32. R distrar's Signature State Registrar

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Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert Edward Grissett March 31, 2011 4:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3330 N. Leisure World Blvd. #1004 Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) D.C. 1 XM 2 F 90 Months July 20, Year)1920 Hours Director 577-16-6186 Usual Residence of Decedent 28a-f shov 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Silver Spring 1 ☐ Yes 2 🖾 No Montgomery ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rral", or items 23a or Examiner must be r Funeral 20906 USA 3330 N. Leisure World Blvd. #1004 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give 1 0 Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: Year or Dates. 1943-45 Specify: Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) the Naval Submarine Design Mechanical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ Robert Edward Grissett Margaret Meding 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3330 N. Leisure World Blvd. #1004, Silver Spring, M 20906 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sho Department of Health an Important: If item 27 Is any injury or other trau Barbara Ann Grissett/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) encombmen Gate of Heaven Cemetery Silver Spring, MD 21. Signatule of Funeral Service Licenses Francis J. Collyins Funeral Home Inc. 00 University Blvd. W. Silver Spring, MD 20901 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a. Prostate Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or ilmury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 2 No death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1 🗌 Yes 2 XNo Other: 1 Inpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ER/Outpatient 3 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

State Registrar

Medical

29a. Certifier

only one) 29b. Signature and title

31. Date filed (Month, Day, Year) APR 04 201

Alok Mathur, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000 Olney-Laytonsville Road, Olney, MD 20832 32 Registrar's Signature

4461Cicm

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Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated,

D55694

City or Town, State)

29d. Date signed (Month, Day, Year)

April 1, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 29 Day 2011 1:10 P M Marshall Scott Grossman March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3333 University Blvd West # 1106 Montgomery Kensington Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min Oct. 24 BrookIvn, NY **Director** 63 947 127-38-4057 Usual Residence of Decedent 28a-f show 10a State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Maryland Montgomery Kensington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3333 University Blvd West # 1106 20895 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner ò 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: Caucasian 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Professor University other traumatic event, Be Department of Health and Mental Hy Important; If item 27 is marked othany injury or others. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Sheldon Landwehr Evelyn Breiter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacob Grossman, Son 5415 Connecticut Ave NW #818, Washington, DC 20015 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 K Cremation 3 ☐ Removal from State Fort Lincoln Crematory April 1,2011 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland M01102 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute KOU 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. erval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Biliary Tract Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Dae to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Fart I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical Completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No. 1 X Natural 5 Pending injury Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.0. Records, Division of Vital

> State Registrar

29b. Signature and title of certifier

Geoffrey Coleman,

30. Name and addre

31. Date filed (Month, Day,

ss of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D37142

1355 Piccard Drive, Rockville, Maryland 20850

March 31, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Manthch 299, 2014 ar Robert Anthony Georgine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Months Days Hours 7/1911/8/1/932 353-22-5739 78 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code . Hygiene. other than "natural", or items 23a or vent, the Medical Examiner must be r 10g. Citizen of What Country? Funeral 301 Valley Brook Drive 20904 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rmed Forces? 1952 Black, White, etc. ģ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Labor Leader AFL-CIO should be filed with and Mental Hygien 7 is marked other the Be 17. Father's Name (First, Middle, Last)
Silvio Giorgini 18. Mother's Name (First, Middle, Maiden Surname)
Rose Menzana ပ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is n any injury or any inj Mary Rita Georgine/Wife 301 Valley Brook Drive Silver Spring, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date □ Cremation 3 □ Removal from State 5 ₺ Other (Specify n tombmen Cemetery cremator or other place)
Onacion of the place 4/04/2011 1 Burial 2 Cremation 3 Hillside, Illinois 4 Donation PNALAPAD RENALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 21. Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Physician/ Cerebrovascular accident disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Seizure Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed Coronary artery disease and -tran Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical Pneumonia attending p as IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Vas 2 No ed by the a 1 ☐ Yes 2 ☐ Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🔀 No ည 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify)

3. Time of Death 0222

9. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between 2 days

Year

death? 1 Tes 2 No

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year) March 29,2011

28d. Describe how injury occurred

City or Town, State)

1 🗌 Yes 2 🏅 No

I'l'I'nois

White

Box 68760 P.0. Records, of Vital Division

e Hospital or Attending Phy: n 24 hours after death. e Funeral Director: After this leted filled in by the funeral di V To the ...
To the Funeral Director the Funeral Director the Funeral Director the Funeral Director that the Funeral Direc

> State Registrar

Certificate:

31. Date filed (Month, Day, Year APR 0 1 2011

29b. Signature and title of certifier

27. Manner of Death

1 X Natural

2 Accident
3 Suicide
4 Homicide

29a. Certifier

(Check

only one)

Accident Suicide

5 Pending

Investigation

determined

6 Could not be

30. Name and address of person who comp Kshama Garg MD leted cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, Md

28a. Date of injury (Month, Day, Year)

back

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

work?
1 \[Yes 2 \] No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D60826

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 **Physician** 29 2011 12:44 AM Jerry Maurice Guynn /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Carroll Westminster If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) 01/10/1927 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Min M 2□ F Director 84 458-28-5383 LA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show "natural", or items 23a or 28a-f shovidical Evarriner must be notified at 1 ☐ Yes 2X No Director MD Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? USA 317 Snowfall Way 21157 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Xes 2 No 44-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No If Yes, Give Year or Dates: Specify ⋛ Specify: White 3 Widowed 4 Divorced 60-63 Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) NASA Journeyman Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Loucille Mitchell William Guynn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a:
Important: If item 27 Is
any Injury or other trau 317 Snowfall Way, Westminster, MD 21157 Nova Guynn/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. 4/1/2011 Garrison, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel 21157 412 Washington Road, Westminster, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Lung mass disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Asbestosis Sequentially list conditions, if any, leading to immediate cause. Enter the carry of Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed and -tran Due to (or as a consequence of) burial-Box 68760. Physician/Medical the ass IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. signed by the a be detached for 1 TYPS 2 TNO 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed Pleural Effusion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certific te 25. Vas case referred to medical examiner? 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: Be 26. Place of Death (Check only one) Hospital: 1∐Yes 2☑No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 00062705 WJL ucinda

Registrar DHMH 17 Rev 1/2001

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LUCINDA

31. Date filed (Month, Day, Year) MAR 3 0

MD

410 MALCOLM DR SUITEC Westminster 21157

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

MUNDORF.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month March 31, 2011 10:38 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10615 New Hope Road Frostburg Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex. 1 M M 2 □ F Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Months Hours Min 69 th, Day, Year) **May 28,** 1941 Maryland Yrs. Director 218-38-2313 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified 1 Yes 2 No Allegany Frostburg Maryland 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10615 New Hope Rd. "natural", or items 23a Funeral 21532-U.S.A 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) 10 College (1-4 or 5+) Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clarence Edward Gomer Mildred V. Lashbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Gomer daughter 20210 Pond Circle Rd, PO Bo Midlothian 21543-Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Frostburg Memorial Park April 04, 2011 Frostburg 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Pur 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final RR Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director. After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 🗆 No g Unknown g Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? performe 2 No 2 1 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural iniurv 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Implementation Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 5 person who completed cause of death (Item 23a) (Type 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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			For State Registrar	State of Marylan		rtificate of L			eq. No.	12000
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat		3. Time of Death
	Physicia /Medic		Hildegarde	Ann		Gee		Month	Day Year 3011	10:59 PM
-	Examin		4a. Facility Name (If not institution, give s	·		4b. City, Town, or		4c. County of Death		
			Lions Center for I				berland			Legany
	Funeral Director		332-12-3010	7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05/17/1	9. Birth Cou 1921 III:	place (State or Foreign ntry) inois
and	MC T		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
Mary	rf sho	tor	MO Buchanar			. Joseph				1∭Yes 2□No
h the	or 28a	irec	10e. Street and Number			10f. Zip Code	-	1	0g. Citizen of What Cou	ntry?
ith wil	23a (ral	3305 Lantern Lan	9		645	506		USA	
er dea	items	Funeral Director		Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination use by motified at once.	by	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		0	White
15-("natu	lete	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation Juring most of workl	ng	16b. Kind of Business/Ir	ndustry
within	than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DO NOT u</i> se retired _. Ceacher)		Public Scho	2018
d 2	Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name			3015
ld be	Aenta rked tic ev	To B	Paul	Glahn			Edna	Her	nrietta S	chlicht
ary shou	and Nis ma		19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (Street &	and Number or Rura	al Route Number	r, City or Town, State, Zi	p Code)
and a	ealth m 27 her tra		John Gee / Son			Box 414,			5753	
Ore ges 1	rof H Fite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Re			sition (Name of matory or other place			20c. Location - City or To	
tim	rtmer rtant: njury		4 □ Donation 5 □ Other (Specify)	Cun		nd Cremato			Cumberland	•
Bal	Depa Impo any ir once		21. Ignature of Funeral Service Dense						ily Funeral land, MD 2	•
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deatle	n. Do not ent	er the mode of dying	g, such as cardiac o	or respiratory arre	est,	Approximate Interval Between
	ysician		Immediate Cause (Final disease or condition	M	eum	ONIA			>	Onset and Death DAYS
	Medical aminer		resulting in death)	Due to (or as a consequent						
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):				-	· .
cuted	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unachytig Cause (Disease or injury that initiated events c.						ĺ	
0 ,	an an Irial-tr		resulting in death) Last	Due to (or as a consequ	uence of):	***				
68760, ifficate be ex	ig physician and as the burial-transit	Medical	d.							
-		Med	IF FEMALE:							
Box eath cer	attendin for use	ian/	in the past 12 months?	 c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 	Ideath 3	Ectopic pregnancy Other (specify)	,		23d. Date of delive Month	ery Day Year
P.O.	y the	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	leatii 5L					
S that	s been signed by the should be detached	by P	Part II. Other significant conditions cont		ulting in the ur	nderlying cause give	n in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
ords	en sig	ed b	HTRIAL F	IBRILA	7101	V_{-}		1 □ Ye	es 2⊠No 3□ Pro	bably 4 ☐ Unknown
ecc law re	S 52	Completed	STROKE					24a. Was ar	n 24b. Were auto	opsy findings available ompletion of cause of
E P	page	Som						autops perform	ned? death?	2. No
Vita ician:	certificate ector, pag	Be	25. Was case referred to medical examiner?			I.e.	26. Place of Death			
Of Physi	this or		TE Tes Zinto	1 Inpatient 2			4 Nursing Hor		ence 6 Other (Speci	fy)
on ding	n. After this funeral di	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Work	rat ? /es 2 □No	28d. Describe ho	w injury occurred	
Division of Vital Records, alor Attending Physician: The law requires the control of the control	after deatl Director:	Certification: To	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, str			28f. Location (St	reet and Number or Rur	al Route Number.
ام الله الله الله الله الله الله الله ال	s affel	Vert	4 ☐ Homicide determined	building, etc. (Specify	v)	,	- [City or Town	n, State)	
Hospit		Medical (29a. Certifier Check only one) Certifying Physical Examin	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the tim vestigation, in my or	ne, date and place, pinion, death occurr	and due to the ca	ause(s) and manner as ate and place, and due t	stated. o the cause(s)
o the	ипли Го th e	Me	29b. Signature and title of certifier	and mariner stated.		29c. License	number	25	9d. Date signed (Month,	Day, Year)
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	1-)5 20H
) ,	10		30. Name and address of person who con	npleted cause of death (Item	23a) (Type,	Print)	, , , ,	,	11/04/01/0	15,3011
) _S;	1-		30. Name and address of person who con	appleted cause of death (Item	Natio	mal Hid	muau.	LaVal	March s	1502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ March 30, 10:20 A M Phyllis Ann Grainger Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lighthouse Nursing Home Ellicott City Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min ^{Year} 928 1 🗆 M 2 💢 F Days June 17 Director 536-22-6047 82 Washington Yrs Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland| Prince George's Bowie ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 12708 Buckingham Drive 20715 U.S.A. hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Arthur Joseph Bagley Sylvia Louden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Jana Castle/Daughter 10325 Tailcoat Way, Columbia, Marvland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lake View Cemetery 4 Donation 5 Dother (Specify) 04/06/2011 | Lake View, S.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) burial-tran and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an perform 2 No 2**X X**No 1 Tes filled in by the funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital: 2 X No 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6X Other (Sp. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of : After t Certificate: 28c. Injury_at 28d. Describe how injury occurred 1**XX**Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be s after death Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Hospital Medical X Certifying Physician To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Pr ctioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) UND D47447 03/31/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Lazris, 6334 Cedar Lane, Suite 103, Columbia, Maryland 21044 31. Date filed (Mont Registrar's Signature State APR 01 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:57 p M 990 201 Year Arno1d Gross March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Deat Holy Cross Hospital Silver Spring Montgomery Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🖳 M 2 🗆 F Washington, 213-38-2505 09490694940 **Director** Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 X Yes 2 □ No 1705 Billman Lane 10f. Zip Code 2 Funeral 10g. Citizen Sf What Country? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 4 Yes 2 Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Esterman Estate Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Jeweler Jewelers Be 17. Father's Name (First, Middle, Last)
Morris Gross 18. Mother's Name (First, Middle, Maiden Surname) Mildred Wishnoff 19a. Informant's Name/Relationship (Type, Print) $^{19b.\,Mailing}$ Address (Street and Number or Rural Route Number, City or Town, State, Zip Code $1705\,$ Billman Lane Silver Spring, MD $20902\,$ Ann-Louise Gross - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Judean Mem. Gardens 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 04/01/2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Liee Edward Sage of Funeral Direction Inc. M01163 .091 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 day Immediate Cause (Final Physician/ disease or condition resulting in death) a Acute Myocardial Infarction Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examiner Due to (or as a consequence of): e attending physician and ed for use as the burial-tracsi Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Character at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Yea 1 Yes 2 No ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease Division of Vital Records, 1x Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 😾 No Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director. After thi

Tompleted filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛣 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation M 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 019192 April 1,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry Hecht M.D. 3941 Ferrara Dr. Wheaton, MD 20906

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) APR 05 2011

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GREENE 03:37 M 2011 MARCH AYLEN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 Min. Months Davs Hours Month, Day, Y Country) Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "naturo" any injury or other traumatic ence. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2X No Damascus Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20872 10627 Shasta Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Š Black 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked Infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Shavani Greene unascertainable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10627 Shasta Court, Damascus, Maryland 20872 Shavani Greene, mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Fort Lincoln Crematory 4/6/2011 Brentwood, Maryland 4 Donation 5 Other (Specify) Simple Tribute 21. Signature of Funeral Service Licenses MO1102 22. Name and Address of Facility Rockville, Maryland 20852 1040 Rockville Pike, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Ph sician/ EXTREME PREMATURITY disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. E. ter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): eatending physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Other (specify) ate has been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No death?
1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 2 X No ည 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: injurv 1 X Natural 5 Pending s after death. Investigation the f Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 3 🗆 within 2 To the I only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 63554

Registrar DHMH 17 Rev 7/2009

State

GAYLE

31. Date filed (Month, Day, Year)

MONTGOMERY VILLAGE AVE #EZO

ames. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

19241

2. Registrar's Signature

V. SKINNER

APR 05 2011

MARCH 30

2011

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:45 P Andrew Golmic April 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bethesda Health and Rehabilitation Bethesda Montgomery 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
July 7,1920 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) **Funeral** 9. Birthplace (State or Foreign Birtripio Country) PA Days 1X M 2 □ F Hours 90 Director 525-32-5747 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director D.C. None Washington 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2141 P Street, N.W. #408 20037 USA death v 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces' þ 1 Never Married 2 Married Black, White, etc. 1 Yes If Yes, Give 2 No 1942-72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 X Widowed 4 □ Divorced 1944 Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Steelworker Steel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Golmic Anna Horanich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Indoorself in Indoor 2141 P St., N.W. #408 Washington, DC 20037 Fr. Marcell Pytlarz/friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) April 7,201 Aliquippa, PA Mt. Olivet Cemetery 21. Signatur / Funeral 39 ice Licent 22. Name and Address of Facility DeVol Funeral Home M01315 2222 Wisconsin Ave., N.W. Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Atherosclerotic Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Hypertension death? perform Dementia Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 X No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) how du D43121 April 4, 2011 30. Name and address of person who completed ca use of death (Item 23a) (Type, Print) Nurul Chowdhury, 15216 Dino Drive Burtonsville, MD 20866 31. Date filed (Month, Day, Year) State APR 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Martin E. Gerel 4:15 a M April Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral . Age (In vrs. last birthdav) Davs Hours 10/27/1918 1 🔀 M 2 🗆 F 92 069-16-3879 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1-Yes 2 No Rockville Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Appartment of Health and Mental Hygiene.

Apportant: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b 11903 20852 US Bristol Manor Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2X Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Law Firm Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Benjamin Gerel Jennie Feinsilver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Selma Gerel/Wife 11903 Bristol Manor Court Rockville, Md. 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 Ϊ Removal from State Star of David ች/7/11 North Lauderdale, F1. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Edward Sagel Funeral Direction Jamie Arthurs 20852 1091 Rockville Pike Rockvi 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Critical Aortic Stenosis Medical resulting in death) Due to (or as a consequence of): Examiner Cardiomyopathy Ischemic Sequentially list conditions, if any, sading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing death), act. Physician/Medical Examiner attending physician and for use as the burial-transit To the Hospital or Attenting Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by myelodysplastic syndrome 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? death? 1 Yes 2 No Yes 2x No within 24 hours after death.

To the Funeral Lirector: After this certifical completed filled in by the runeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛣 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Casey House 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🔲 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30

Registrar

State

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph

Bindu C.

D0060634

6001 Muncaster Mill Rd. Rockville, Md. 20855

4/1/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month Gehrels, Jr. March 30, 6:40 Ernst а м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Montgomery Montgomery Hospice-Casey House Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. 1 X M 2 □ F Country)CA Ma^{(Month}, 6^{Day, Y}1^{ag}30 Director 567-40-6934 80 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Rockville Montgomery 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 5515 Dowgate Court 20851 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. 9 1 X Never Married 2 Married ģ within 72 hours after 1 ☐ Yes 2 X No Specify: Specify.White If Yes, Give should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", Completed 3 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Engineering Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Unknown Ernst Gehrels, Sr 19a. Informant's Name/Relationship (Type, Print)
Paul T. Stein/Personal Rep. 19b Mailing Address (Street and Number or Rural Route Number City on Tayrn, Sigte Zip Code) 25 West Middle Lane, Rockville, MD 20850 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State April 4, 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. \$00 University Blvd. W. Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that cause. The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Ischemic Cardiomyopathy yrs Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 3 Month Year Pregnant at time of death Dav 1 ☐ Yes ∠ ☐ Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law in within 24 hours after death.

To the Funeral Director: After this certificate has the completed filled in by the funeral director, page 2 s. autopsy performed? Yes 2 No 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Other: 1 🗌 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142

Registrar DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

#100, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
G. Coleman, MD 1355 Piccard Drive,

G. Coleman, MD

APR 05 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

			For					Health and M	-		•	10070
		_	State Registrar			Cer	tificate of l	Death		Reg. N	2011	12673
ı	Physicia Medic		1. Decedent's Name (First, Middle, Lass Martina Garcia	•					2. Date of Dea	D.	011 Year	3. Time of Death 4:50 a M
2000	Examir		4a. Facility Name (if not institution, give	r Location of Death	-	40	. County of Deati					
-	_		4715 Aspen Hill Resolution		o (In um la	at hirthday	Rockv	ille I If Under 24 Hrs.	8. Date of Birt		Montgome	
	Funeral Director			M 2 13 x F 7. Ag	85	st birthday) Yrs.	Months Days		NoW. 39	y, Ygag	25 Domi	hplace (State or Foreign Intra) nican Republi
	/land f shov ed at	tor	10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	e Man r 28a- notifie	Director	MD Montgom 10e. Street and Number	ery		Rocky	rille 10f. Zip Code					1 Yes 2 X No
	with the		4715 Aspen Hill	Road				853		-	itizen of What Co SA	untry?
11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?								lispanic Origin? (Specan, Mexican, Puerto R Specify: Domin			14. Race - Amer Black, White Specify: Whi	, etc.
2-0	2 hour "natu	plet	15. Decedent's Ed (Specify only highest gra	ducation		16a. Deced	lent's Usual Occup	pation during most of workin	a	16b. l	Kind of Business I	ndustry
2121	within 7; /giene. ner than t, the Me	• Completed	Elementary/Seconday (0-12) None	College (1-4 or 5	5+)	life. DO	onoruse retired) omemaker			0	wn Home	
Maryland 21215-0036	ld be filed Mental Hy arked ott atic even	To Be	17. Father's Name (First, Middle, Last) Santo Garcia					18. Mother's Name Enrique			Surname)	
, Mar	nd 2 shou salth and n 27 is m		19a. Informant's Name/Relationship (Ty Juana F. Garcia/	_{oe, Print)} Daughter	7			and Number or Rural 11 Road,				
Baltimore,	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition ★★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	20b. Pi	lace of Dispo- emetery, cren e of He	sition (Name of natory or other place eaven Cem	etery Apr	il 8,		ocation - City or ver Spri	
Balt	permit. Departr Import. any inji		21. Signal read Funeral Service License	Cole		ŕs	Name and Addre	sity Blvd.	Funeral			,MD 20901
ا بعد	Physician/ Medical		23a. Part 1. Enter the disease, of some shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Congesti	ve He	art Fa		g, such as cardiac or	respiratory arr	rest,		Approximate Interval Between Anset and Death 3 MOS •
	Examiner			Due to (or as a			sease					10 yrs.
	p _ B	Examiner	Sequentially list conditions, in the list cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
0	ficate be executed g physician and as the burial-tranit	ical	that initiated events resulting in death) Last	Due to (or as a	a consequ	ence of):						
Box 6876	ath certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes _ 2 X No	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	су			23d. Date of deli Month	very Day Year
P.O.	requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions co	ntributing to death b	ut not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco	use contribute to	the cause of death?
ds,	quires en sign	ted b	Cerebral Vascular	Disease					1 🗆 \	Yes 2	⊠ No 3 □ Pr	obably 4 🗆 Unknown
Division of Vital Records,	he law rer te has be age 2 sho	Completed				_			24a. Was a autop perfor	SV	prior to c	opsy findings available ompletion of cause of
E	clan: T ertifica ctor, p		25. Was case referred to medical examiner?		W 100 100		26. PI	ace of Death (Check		2 15 19	oj imies	Z LI NO
Ž	Physician: The lav r this certificate haveral director, page 2	입	1 ☐ Yes 2 XXNo 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatien 28b. Time of	t 3 DOA Oth	4 ☐ Nursing Hom				fy)
ion o	l or Attending Ph after death. Director: After th I in by the funeral	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day		injury	work	y at (? Yes 2 □ No	8d. Describe h	ow injui	y occurred	
Divis	ital or Att irs after d al Direct led in by		4 Homicide determined	28e. Place of Inju building, etc			eet, factory, office	2	8f. Location (S City or Tow		d Number or Run)	al Route Number,
	To the Hospital within 24 hours a To the Funeral to pompleted filled	Medical	(Check 2 Medical Examir	ner: On the basis of ea	xamination	and/or invest	gation, in my opinio	, date and place, and on, death occurred at t	he time, date ar	nd place	and due to the c	ause(s) and manner stated
	To the within To the Somple	Σ	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the	best of my	knowledge, d	eath occurred at the 29c. License				s) and manner as a te signed (Month)	
)	2		> Illen (9)	darrele	DNF	CRU	PRO	86637	7	SI	Rif	4,2011
			30. Name and address of person who co Ellen Reilley Farr	ell, CRNP	eath (Item	23a) (Type, P 3250 S	tarting (Gate Court	, Woodl	bine	e, MD 21	797

State Registrar 31. Date filed (Month, Day, Year) APR 05 2011

32 Registrar's Signature pares

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH 10-30A M ONSTANTINE 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Burtonsville Montgomery Sanctuary at Holy Cross Nursing Home Birthplace (State or Foreign Country) 6. Sex 1 **X** M 2 \square F If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months 09/14/1922 Illinois 578-42-1929 88 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland at Director notified 1 🗌 Yes 2 🗶 No 28a-f Laurel Howard Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or Funeral with 10641 Glen Hannah Drive 20723 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?
1 X Yes 2 No 1943 Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 1946 Completed 3 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Postal Service Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last, ည Irene N. Diamond Nicholas C. Ganas permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any Injury or other traumatic v 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10641 Glen Hannah Drive, Laurel, Maryland 20723 Jean Lewis Ganas - Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Lincoln Crematory: 04/08/2011 Brentwood, Maryland Donation 5 Other(Specify) ture of Funeral Servic 22. Name and Address of FacilityHines-Rinaldi Funeral Home, Inc. 21. Sign M0020 11800 New Hampshire Ave., Silver Spring, MD 20904 Jeres 23a. Part 1. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lifest failure. List only one cause on each line.

Immediate Cause (Final disease or condition and the cause of t NISETHEL Physician/ Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) ed by the 9 Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 s autopsy performed death? No DZ certificate 1 🗌 Yes To the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \square Yes a No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, mpleted filled in by determined City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractioner To the best of my high one of a control of the last of the cause (s) and manner as stated. (Check within 2. 29b. Signature and title of certifier 29c. License number 1)28595 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAED 2835 AKHANI TASNEEM 31. Date filed (Month, Day, Year) Registrar's Signature APR 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 0 1 1 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certi	ficate of	Death			F	Reg. No.			
Physici		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year								3. Time of Death			
ledical Exami	ner	Andrew David (Oh: Tour	al anation o		pril 8, 2		County of	Dooth	1631 hrs
		4a. Facility Name (if not institution Frederick Memorial H		,	45	b. City, Town, o Frederick	r Location o	n Deam			rederick		
Funeral		5. Social Security Number		je (In yrs. last	t birthday)	If Under 1 Ye	ar If Unde	r 24Hrs. 8.	. Date of B	irth(MM/I	DD/YYYY)	9. Birth	nplace (State or
Director		215-37-7230	1 X M 2 F	18	Yrs.	Months Day		Min	10/05/			Foreign	
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Locatio	n							10d. Inside City Limits
	tor	Maryland F 10e, Street and Number	rederick			Jef 10f. Zip Code	ferson			10a Citi-	en of Wha	at Count	1 Yes 2 No
ith the Maryland 23a or 28a-f sho	Il Director	3629 Fry Road					21755			Unite	d Stat	tes c	of America
Baltimore, MD 21215-6036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumante event, the Medical Examiner must be notified at once	Funeral		arried Armed Forces' 1 Yes 2 orced If Yes, Give Year		If Ye	Decedent of H s, specify Cuba	n, Mexican,				White,	etc.	an Indian, Black, hite
rs afte	ğ	3 Widowed 4 Div	or Dates:	moleted) 1		Yes 2 X No		kind of work	done		Specify: and of Bus		
2 hou	ete d	Elementary/Secondary (0-12)	College (1-4 or			st of working life							,
5-0036 ted within 72 hours of Hygiene. other than "natury the Medical Exami	Ccmpleted	12				None						None	2
5-CO led wit Hygien other		17. Father's Name (First, Middle,	Last)					s Name (Fir			Surname)	# 0 # 0 # 0 # 0 # 0 # 0 # 0 # 0 # 0 # 0	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	David Garman			180 11 90			Allison					
, MD 21215-603 and 2 should be filted within ealth and Mental Hygiene. tem 27 is marked other tit fraumatic event, the Med	٥	19a Informant's Name/Relations David Garman	/ Parents			Address (Stre						, State,	Zip Code)
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		Allison Garman 20a. Method of Disposition 1 Burial 2 Cremation		ato cre	ice of Dispositematory or other	ion (Name of ce		April	12,	20c. L	ocation - (•	Town, State
time: Page the trant:		4 Donation 5 Other Sp		Sunci	hsburg C			2011			ithsbu	rg, l	Maryland
Balt permit. Depart Import		21. Signature of Funeral Sorvice	Licenspe	M01433	² Kee 106	ne and Address ney & Ba East Ch	sf ord F urch St	A. Fu	neral Freder	Home ick,	Maryla	and 2	1701
Physician		23a. Part I. Enter the disease, or failure. List only one cause		the death. D	o not enter the	mode of dying	, such as ca	ardiac or res	spiratory ar	rest, sho	ck, or hear	rt	Approximate Interval Between Onset and
/Medical £xaminer		Immediate Cause (Final disease	a Meningoer		litis v	vith con	mplica	ations	S				Death
		or condition resulting in death)	Due to (or as a cons	equence of):									
	9	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a cons	carron of:									
ted d ansit	ă	events resulting in death) Last	d.	equence on).									
760, cate be executed physician and the burial - transi	Medical	₩ UNPENDED		27 50		915 5-2	2_11	Cm.					
760, ficate be es physician the burial	Med	IF FEMALE:	23c. If yes, outcome							230	l. Date of c	elivery	-
		23b. Was decedent pregnant in the past 12 months?	Cive Birat	time of death	_ ==	al death 3	Ectopic	pregnancy			Month	D	ay Year
Box 68: death certifi the attending	Physician	1 Yes 2 No 9 Unit	(nown 9 Unknown	time of death	1 5 Othe	er (Specify)							
D. B. 1 the de by the ached f		Part II. Other significant condit	ions contributing to deat	h but not resu	ulting in the un	derlying cause	given in Par	rt I.	23e. Did	tobacco u	use contrib	ute to t	he cause of death?
of Vital Records, P.O g Physician: The law requires that to the this certificate has been signed by nearl director, page 2 should be detail	d b								1 Ye	s 2	No 3	Proba	ably 4 🗸 Unknown
ords, v requires s been s should	Completed								24a. Was auto				opsy findings available ompletion of cause of
eco ne law te has ge 2 s	Ē		<u>-</u>							ormed?	de	eath?	
tal Rection: The certificate ector, page		25. Was case referred to medica				26.Plac	e of Death (Check only	W	2		100	2 110
Vita	To Be	examiner? 1 ✓ Yes 2 No	Hospital:	ent 2 Ef	R/Outpatient	3 DOA	Other4	Nursing Ho	ome 5	Reside	nce 6	Other:	
of ing Pt After uneral		27. Manner of Death	28a. Date of Inju (Month, Day,)		8b. Time of Inj		iry at Work?		I. Describe	how inju	гу оссите	d	
tendi leath. tor:	atio	1 X Natural 5 Pend 2 Accident Inves	stigation				Yes 2						
Division of Vital Records, 19.0. Box 68' Hospital or Attending Physician: The law requires that the death certifi 24 hours after death. Funeral Director: After this certificate has been signed by the attending tell filled in by the funeral director, page 2 should be detached for use as	Certification:		d not be (Specify)	njury - At hom	e, farm, street,	, factory, office	building, etc	c. 28f.	Location or Town,		nd Number	r or Rur	al Route Number, City
Dispital ospital on the post and post a		4 Homicide	10,000)/										
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	(Check only	nysician: To the best of m miner:On the basis of exa and manner stated.										
H 3 F 3	×	29b. Signature and title of certifie				29c, Licen							th, Day, Year)
		mi m	,			0.0	M.E.			Apri	l 11, 20 [.]	11	
		30. Name and address of person Ling Li, MD Assista	who completed cause of ont Medical Examine		-	, Baltimore,	MD 2120	01					
St	ate	31. Date filed (Month, Day Year)	32. Registr	rs Signature	100	barker							
Regist	trar	AFR	19 2011	num	14. 14	auto							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ 12:50а м Chai Ngoc Ha 31 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Vietnam 1 🗆 M 2 🎗 F Months Days Hours Marty 88, 1960 50 Director 212-23-7802 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Olney Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 20832 3402 Pisner Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Asian "natural" 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic
once. (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electronics Technician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Phung Hao Binh На 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3402 Pisner Terrace, Olney, Maryland 20832 Chee Keong Kong - Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 04/07/2011 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Signature of Funeral Service Licenses me Mane Warken 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final Physician/ Breast Cancer with Metastases disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consquence of): if any leading to immedicause. Enter Underlying dansit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE signed by the attending to be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform yes 2 X No 1 Yes 2 No certificate r: After this certifica e funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 🖄 Other (Specify) Hospital: Hospice 2 X No 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury within 24 hours after death.

To the Funeral Director: After Completed filled in by the funeral process. 1 X Natural 5 Pending WOFK: 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) March 31, D37142

Registrar DHMH 17 Rev 7/2009

State

Geoffrey Coleman. 31. Date filed (Month, Day, Year,

APR 04 2011

30. Name and address of person who completed cause of death (Italiza) (Type, Print)

Geoffrey Coleman, M.D., 1355 Piccard Drive, Suite 100, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 12677 State of Maryland / Department of Health and Mental Hygiene

•	1- For State Registrar		Certificate of D	eath		Reg. No.	
Physician	1. Decedent's Name (Firs				2. Date o Month	Day Year	3. Time of Death 0958 hrs
Medical Examine	-		Herrera	City, Town, or Locatio		4c. County of	
) _	Howard County		(olumbia		Howard	
Funeral Director	5. Social Security Numbe	1	_	f Under 1 Year If Un Months Days Hou	un Adin	of Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign Mexico Country)
any	Usual Residence of Dece 10a. State 10b. 0		c. City, Town or Location				10d. Inside City Limits
	MD I	Howard	Laurel				1 Yes 2 No
to 28a-f show iffed at once.	10e. Street and Number		1	of, Zip Code		10g. Citizen of Wha	at Country?
3a or 3		nington Blvd.		20723		Mexi	
or items 23s or 28s-f sho must be netified at once.	11. Marital Status 1 X Never Married 2	12. Was Decedent Even Armed Forces?		ecedent of Hispanic C specify Cuban, Mexic			- American Indian, Black, etc.
er de	3 Widowed 4	1 Yes 2 Divorced If Yes, Give Year	[™] No	s 2 No specia	Mexican	Specify:	White
ours aft stural' samine		on (Specify only highest grade comple		Jsual Occupation (Giv of working life, DO NO		16b. Kind of Bus	iness/Industry
5-0036 led within 72 hours Hygiene. I other than "natur the Medical Exam	Elementary/Secondary 5	(0-12) College (1-4 or 5+)	Lobo	_	, r doo reared,	Groo	cery
-0036 d within 'giene. ther than	17. Father's Name (First,	Middle, Last)		18.Moth	er's Name (First, Mic	ddle, Maiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medic	unknown					Herrera	
		elationship (Type, Print) broth	ner 19b. Mailing Ad	•		Number, City or Town	i, State, Zip Code) ∋ , Md • 20763
e, MD I and 2 sh Health and item 27 is r traumat	EZEQUIEL 20a. Method of Disposition	<u>Herrera Paz/</u>	20b. Place of Dispositio	(Name of cemetery,	Date		
<u>~</u> ~ ~ 3 ≥ 1	1 X Burial 2 Cr	emation 3 X Memoval from State	crematory or other Municipal	Cemeter	y 4/16/2	01 Duan C	City or Town, State Venir, San Otzocon, Mixe , Mexico
Baltimo permit. Page: Department o Important: injury or oth	21. Sign turk of Full eral						RVICE, P.A.
	Merry	ase, or complications that caused the	924	1 Columb.	ia Blvd.	Silver Sr	oring Md20910
Physician //Medical	failure. Listernly one	cause on each line.		node of dying, sacrifes	cardiac or respirato	ry 6/1631, 3/100K, 0/ 1/04	Between Onset and Death
xaminer	Immediate Cause (Final or condition resulting in c						
	Sequentially list condition if any, leading to immedia		ence of):				_
Pysed nsit	cause. Enter Underlying	Cause c.		- EQ. 14			
and transit		Last Due to (or as a consequence d.	ence of):				
	X UNPENDED	☐ AMENDED 23a,	27, per me, g	17 7-7-11	sm	1	
760, icate be ex physician the burial		23c. If yes, outcome of			pic pregnancy	23d. Date of o	delivery Day Year
Box 687 death certific the attending profess of the set of the s	past 12 months?	4 Pregnant at tim	2 Fetal e of death 5 Other	(Specify)	pic pregnancy		33,
that the death certificate by the attending detached for use as the by the state of the second control of the	1 Yes 2 No 9	Unknown 9 Unknown conditions contributing to death but	at not reculting in the und	artying cause given in	Part 1 23e	Did tobacco use contril	oute to the cause of death?
P.O. es that the gened by be detac		conditions contributing to death but	it not resulting in the und	snying cause given in			Probably 4 🗸 Unknown
ords, P.O. aw requires that as been signed to 2 should be detail					24a.		Vere autopsy findings available nor to completion of cause of
Records, P.(The law requires that ficate has been signed ; page 2 should be det	<u> </u>			-	1	performed? d	eath? ✓ Yes 2 No
Vital Rayscian: T					th (Check only one)		
Physical arthis of all directions of the physical directions of the physica	1 Yes 2	NO _	2 ✓ ER/Outpatient 3		Nursing Home	5 Residence 6 cribe how injury occurre	Other:
ading of the function of the f	27. Manner of Death	28a. Date of Injury (Month, Day, Year) Pending	200. Time of inju	1 Yes 2	-	and the most injury occurre	
Division of Vital Records, tal or Attending Physician: The law require is after death. To Director: After this certificate has been siled in by the funeral director, page 2 should be attification: To Be Completed.	2 Accident 3 Suicide 6	Investigation 28e. Place of Injury	r - At home, farm, street, f	actory, office building,			er or Rural Route Number, City
Division o spiral or Attending nours after death. neral Director: After filled in by the fune	4 Homicide	determined (Specify)			OFIC	own, State)	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the delinest forthfination: TO Be Completed by Divisional Machine 1		fying Physician: To the best of my king cal Examiner: On the basis of examiner	nowledge, death occurred ation and/or investigation	at the time, date and , in my opinion, death	place, and due to the occurred at the time	e cause(s) and manner date and place, and di	as stated. ue to the cause(s)
	29b. Signature and title o	and manner stated. f certifier		29c, License numb	er		ed (Month, Day, Year)
3-PEND	2-~)		O.C.M.E.		April 10, 20	11
	30. Name and address of Donna M. Vince	person who completed cause of deat nti, MD Assistant Medical		enn Street, Baltii	more, MD 2120	1	
Stat							
Registra	T APR	13 2011 Jenus	13. 19 was				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 24a per doc g915 5-9-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ March 23, 2011 3:00 pm M Mary Frances Harrod Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Marv's St. Mary's Hospital Leonardtown 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral (Month, Day, June 28. untry) MD 1 □ M 2 🕱 F 62 Director 216-50-9777 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔼 No MD Saint Marys Park Hall 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Completed by Funeral USA 20667 18414 Point Lookout Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Armed Force: Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3

■ Widowed 4

□ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 land Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Certified Nursing Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mary Boome Arthur Brooks permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic s once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 46503 Franklin Road, Lexington Park, MD 20653 Gloria Harrod-Baker - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Western Cemetery April 1, 2011 Prince Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Sewell Funeral Home, P.A. 22. Name and Address of Facility Glade 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final brain Physician/ Medical resulting in death) Due to (or as a consequence of): 40 hours Examiner brain anotic injury Sequentially list conditions, Examiner Due to or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury aspiration hours DNEUMONIA attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical bowel Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Hospital or Attending Physician: The law requires that une ucaun 24 hours after death.

Funeral Director: After this certificate has been signed by the atteleted filled in by the funeral director, page 2 should be detached for its page. in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by chronic kidney disease 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available diabetes 24a. Was an prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certificate: To 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Division 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 0068279 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leonardtown, MD 20650 McCord Michael MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Frank Ellsworth Hillyer 2011 April 11:42 a^M 4c. County of Death Cecil 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Port Deposit 14 Jackson Park Road 8. Date of Birth (Month, Day, Y Dec 19 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours 554-28-1221 1 🕅 M 2 🗆 F 91 California 1919 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location 1 Yes 2 XNo Maryland Cecil Port Deposit 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 21904 U.S.A. 14 Jackson Park Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11 Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give 1 € 1 ☐ Yes 2 ☑ No Specify: Specify: White Year or Dates. 1941-61 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry
V.A. Medical Center (Specify only highest grade completed) Elementary/Seconday (0-12)
Twelve Years College (1-4 or 5+) Processing and Distributing Perry Point, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Bond Cecil Hillyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Jackson Park Road, Port Deposit, Maryland 21904 Jeannette N. Hillyer (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
R.A.Ferris & Co., Inc. 20c. Location - City or Town, State West Chester, 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 04/05/11 4 Donation 5 Other (Specify) Pennsylvania ²² Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P
Reserved 11e Marvland 21903-0766 21. Sign ture of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final MYOCAROIAL disease or condition resulting in death) Due to (or as a consequence of) DISEASE YEARS CORONALY ARTENY Due to for as a consequence of YEARS HYPEN TEN SLOW Due to (or as a consequence of) YEARS HYPERLIPIDEMIA 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Month Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes 24a. Was an autopsy

Ph sician/ Medical **Examiner**

attending physician and for use as the burial-tran

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Important: If ite
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ō r items 23a or ner must be r

Page 1 and 2 should be filed within 72 hours after death with the Maryland πent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death? Yes 2 X No 1 Yes 2 XNo

25. Was case referred to medical examiner' 1 ☐ Yes 2 XNo

27, Manner of Death

1 Natural

Accident

Suicide

only one)

Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of

injury

26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifie

MO

5 Pending

Investigation

6 Could not be

🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

City or Town, State)

29b. Signature and title of certifie

3 □

11774500

29d. Date signed (Month, Day, Year) 5,2011

ELKTON MAKYLAND 2192)

28f. Location (Street and Number or Rural Route Number,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET SUITE #3

GAR-EL

32. Registrar's Signature

304-306 NORTH

3+1VA

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2011 Physician/ Herbert Huffman G. 9:00 A^{M} Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson 9. Birthplace (State or Foreign Country Virginia 5. Social Security Number Sex 1▲ M 2 ☐ F '. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Months 10-9th Day 923 87 **Director** 223-24-3863 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits aţ 10a, State 10b. County Director Examiner must be notified 1 Yes 2 XNo Middle River MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a or Funeral USA 21220 210 Riverthorn Road items should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1¾ Yes 2 No If Yes, Give Year or Date¶ 944–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: White Completed 3 ₩ Widowed 4 Divorced other traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 4 Antique Dealer Antiques Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roxie Riddle Charles Huffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 6915 Pine Valley Drive, Glenn Dale, MD 20769 Charles Z. Huffman/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 04/04/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Fone Service Licensee 22. Name and Address of Facility Beall Funeral Home Bowie MD 20715 NW Crain Hwv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MALA Medical Due to (or a a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Day Month Year Pregnant at time of death 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{\text{Nursing Home}}\) 1 \(\text{Residence}\) 2 \(\text{Other}\) Other (Specify) HOSPICE 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 Yes 2 No Natural Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 405130M Svitados CHARIBS ST

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month

Registrar's Signature

4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Charles William Hessong Month 10:30 P M April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3530 Garfield Road Smithsburg Frederick 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 23, 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months 1**x**□ M 2 □ Hours 216-22-9914 Director 84 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified Frederick Smithsburg 1 Yes 2X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3530 Garfield Road 21783 U.S.A. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S 14 Race - American Indian Armed Forces' Army 1944 9 1 Never Married 2 Married Yes 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White "natural", Completed 3 🕅 Widowed 4 □ Divorced 1947 Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Sadie E. Brandenburg James E. Hessong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau (Daughter) 8419 Cabin Branch Crt. Manassas, Virginia 20111 Jeanne A. Endrikat 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mark's Lutheran April 16. Wolfsville, Maryland 2011 Cemeteru Church 21. Signature of Funeral Service License 22 Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ 5 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** VV Sequentially list conditions, Examine tany, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No rate has been signed by the page 2 should be detached Unknown g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certificd completed filled in by the funeral director, I or Attending Physician; 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death Certificate: 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Fortifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🖂 the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 2 40054451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22911 han 31. Date filed (Month, Day, Year 32. Registrar Signature State Registrar

O DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Victor Hernandez 03/29 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 **X**M 2 □ F Days Hours 35 **Director** None Usual Residence of Decedent 28a-f show at 10a. State 10c. City, Town or Location Director "natural", or items 23a or 28a-f sh edical Examiner must be notified Silver Spring Md Montgonery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11526 Stewart Ln 20904 Honduras filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after peartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or 1 🛂 Yes 2 🗆 No. Specify: Hondu∷aS Specify: Hispanic Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Construction Labor other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Juan Granados Magia Encarnacion Hernandez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Corina Granados/Sister 11526 Stewart Ln Silver Spring, Md 20904 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) General Cemetery 04/11/11 Honduras 22. Name and Address of Facility John T. Rhines Funeral Home 21. Signature of Juneral Service Licensee 3005 12th. St. NE Wash. D.C. 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final Physician/ 'I-Cell Lymphoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin ysician and e burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 phys the L attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page 25. Was case referred to medical examiner? 26. Place of Death (Check only one) **Division of Vital** Be Hospital: Other: 1 🗌 Yes 2 X No ည 1 ☐ Inpatient 2 😾 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending thin 24 hours after death.

the Funeral Director: After mile of the funeral by the funeral by the funeral fune 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4:25 pM

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Betweer

Onset and Death

2 No

1 Yes

1X Yes 2 ☐ No

Honduras

State Registrar DHMH 17 Rev 7/2009 Richard Nguyen, M.D.

31. Date filed (Month, Day, Year) APR 05 2011

1500 Forest Glen Rd. Silver Spring, Md 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 901 Ò 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Univ of NIA Baltimore hoch mD If Under 1 Year If Under 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Date or bird. (Month, Day, 1 X M 2 🗆 Months Hours Min. 578-64-4781 1948 South Carolina Director 62 Nov. Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Charles 1 🗌 Yes 2 😾 No Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5386 Emma Lane 20640 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a Decedent's Lisual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Environmental Tech U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie James Jolly, Sr. Carrie Mae McCorkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria A. Jolly Wife 5386 Emma Lane, Indian Head, Md. 20640 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) April 6, 2
Metropolitan Funeral Service 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Fune of Ser Wilmand Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAM To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months? Dav Year 5 Other (specify) 2 No 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pade perform 1 ☐ Yes ∠X No 1 Tes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ☐ Natural 5 Pendina 2 Accident 3/29/21 UNK 1 🗌 Yes 2 🗷 No Investigation the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State)
5386 Emma Lane India filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated 29b. Signa 29c. License number 30 Name and address of n who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2011 3:15 Dale Jahn James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's City St. Mary's 47893 Snow Hill Way If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) **Funeral** Days Min. 1 X M 2 □ F Months Hours Country 12/30/1934 Director 472-36-3312 76 Minnesota Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No St. Mary's City Maryland |St. Mary's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 20686 47893 Snow Hill Way 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 Never Married 2 A Married Maryland 21215-0036 1 🗌 Yes 2 💢 No Specify. Specify: 3 Widowed 4 Divorced "natural" Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Government Contracting Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>Marie Josephine Swalinkawich</u> William Leon Jahn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) St. Mary's City, MD 20686 47893 Snow Hill Way, <u>Marlene A. Jahn/Wife</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 Cremation 3 Removal from State St. Michael's Cemetery 04/15/2011 Ridge, Maryland 4 Donation 5 Other (Specify) Sign eral September Septem 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Sign 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cardio pu monas Physician/ Medical resulting in death) **Examiner** wordhi Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria **Medical** Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Physician/ 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a 9 Unknown Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 N prior to completion of cause of death? this certificate 1 Yes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred Certificate: After t (Month, Day, Year) the Hospital or Attending Natural 5 Pending 1 Yes 2 No death. M 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director: A
completed filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location /Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month. Day, Year) and title of certifier 29c. License number 29b. Signatura D4259 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey 5. ______31. Date filed (Month, Day, Year) 4 2011 26840 Point Lookout Road, Leonardtown, MD Jeffrey C. Brown, M.D. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 12:15 P^M Mildred Theresa Bean Jurovaty April Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Lexington Park St. Mary's 19569 North Snow Hill Manor Road 9. Birthplace (State or Foreign Country) Maryland Social Security Numbe 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 🗌 M 2 🗓 F Months 90 Yrs. Director February 1, 1921 577-24-2075 Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a to 28a t 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Maryland St. Mary's Lexington Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 19569 North Snow Hill Manor Road 20653 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service Post Master Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, 6 permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. traumatic James Alphonsus Bean Daisy Agnes Hebb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Vallandingham / Niece 21705 Indian Bridge Road, California, MD 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 18 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Lexington Park, Maryland James Catholic Cemetery Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 22. Name and Address of Facility and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each ling Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Other (specify) the funeral director, page 2 should be detached the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) |은 28a. Date of injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State)

within 24 hours after death.

To the Funeral Director, After this certificate Hospital

> State Registrar

Medical

29a. Certifier

30 Name and address q

3 🗆 29b. Signature and title of certifier

31. Date filed (Month, Day, Year,



son who completed cause of death (Item 23a) (Type, Print)

40900 Merchants Lane, Ste. 205, Leonardtown,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registre AMEND#20 locerFH, 4/13/11; BMW, McCo Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2011 Year Month March Physician/ 1:15 am 15 Juanita V. Johnson Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Country Virginia 1 M 2 X F Months Days Hours Min. (121/231/1926 84 Director 565-76-6169 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland items 23a or 28a-f sho ler must be notified at 10a. State Director 1 Yes 2 X No Burtonsville Maruland Montaomeru 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral U.S.A. 20866 15131 Red Cedar Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. the Medical Examiner 5 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Bi-Racial "natural", Completed 3 Widowed 4 Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na amy injury or other traumatic event, the Medic one." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Engineer Domestic 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Lewis Alvin Butler Sara Ethel Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20805 Severndale Terrace. Germantown, MD 20876 Juan Johnson - Son 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of ukn Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State Arlington, Virginia Arlington Natl. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 5-18-2011 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee, M-01564 atrina Silver Spring. MD 20904 won 111800 New Hampshire Ave.. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Septic Shock Physician/ disease or condition resulting in death) Medical Examiner Acute Renal Failure Sequentially list conditions, it cause. Enter Underlying Cause (Disease or iinjury Examiner Due to or as a consequence of Respiratory Failure been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Pneumonia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 1 L Yes 2 L 9 Duknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Decub Ulcer 1 Yes 2 No 3 Probably 4 X Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anemia autopsy page 2 performed? 1 🗌 Yes 2 🗆 No 1 Yes 2 X No Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Certificate: To 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred After X Natural 5 Pending injury 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: At completed filled in by the

🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi March 16, 2011 D68096

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

1500 Forest Glen Road, Silver Spring, MD 20910 Satyam Ashvinkumar Shah, M.D.,

31. Date filed (Month, Day, Year) State APR 04 2011 Registrar

4 Homicide

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per med cert G914 4/21/11 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Physician/ 2011 _A M Hoffman Jamison 10:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Williamsport Williamsport Retirement
5. Social Security Number 6. Sex 7 Washington Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Aug 19, . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Director 220-18-<u>2053</u> 85 1925 Maryland Usual Residence of Decedent 28a-f shov 10a, State 10b. County at 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified Direct 1X Yes 2 No Maryland Washington Williamsport 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21795 USA 154 N. Artizan St items death v 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2 X No within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: XXWidowed 4 □ Divorced "natural" Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Education Secretary injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph McKinley Hoffman Catherine Poffenberger Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myron Bloom, III - Son Mosby Drive Williamsport, Maryland 16621 21795 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1XXBuria from State Cremation 3 🗆 Rem 4 Donation 5 D Other (Spec Greenlawn Mem. Park April 11,2011 Williamsport, Maryland neral Service 21. Sign ure of F Osborne Adenerally Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ zten 11 disease or condition Medical resulting in death) Due to (or as a c / - quence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death ed by the g Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Records. Completed se10 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 🗌 Yes 2 🔲 No To the Hospital or Attending Physician: within 24 ho rs after de.th.

To the Funeral Director. After this certifica completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ြု 2. XNo Other: 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated inhi in Gertifying Nurse Practioner To the best of my knowledge, death-occur diet the time, date and place, and due to the 29b. Signature and till of certifi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mod State gistrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month RANDALL L. JONES April 2011 5:07A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1**∑** M 2 □ F Hours Min Day, Year 56 Director 215-68-5001 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified PA York Delta 1 Yes 2 No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? 23a 36 Norris Road 17314 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married , o ģ 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: Specify.White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Master Electrician injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ပ Russell T. Jones Ada C. Seymour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Kim M. Jones/Wife 36 Norris Road, Delta, 17314 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Donation 5 Communication 3 Removal from State cemetery, crematory or other place) Pine Grove Cem. 4/13/2011 ☐ Donation 5 ☐ Other (Specify) Airville, PA 21. Signature of Funeral Service License 22. Name and Address of Facility Delta, PA Harkins Funeral Home, Inc., 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ U CONTO 161 disease or condition Medical resulting in death) Due to (or as consequence of) **Examiner** Sequentially list conditions, Examine Die to (or as a consequence of): If any, leading to in media cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by CANCER 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Euner, I Director, Aft or this certificate has I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Medical Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David McClure, M.D. 615 W. Mack 615 W. MacPhail Rd. Suite106 Bel Air, MD 21014 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Apronti 2011 1, 12:45 PM Harvey Atwood Kryder, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 12533 Windover Turn Bowie 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 **X** M 2 \square F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Sep. 21 Months Days Hours Min ^{rea}193<u>5</u> Pennsylvania 75 196-26-3223 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified at Funeral Director 1 X Yes 2 No Maryland Prince George's Bowie 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be r USA 12533 Windover Turn 20715 permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1960-1964 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) USDA Veterinarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alice Ogden Harvey Atwood Kryder, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 157 Manassas Circle Daleville, VA 24083 Richard H. Kryder/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mary Tandry Veterans Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/7/2011 Crownsville, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition VENTRI CUCAR FIBRICATION Onset and Death Physician/ Medical resulting in death) HEART FAILURG Examiner SGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be-thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached for Yes _ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERTENSIVE CARDIOUAS CUCAR DIS EASE 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown etes Mellitus. 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No completed filled in by the funeral director, page 2 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 🗆 Yes 2 💢 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending work?
1 Yes 2 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29c. License number è 29d. Date signed (Month. Dav. Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DEPETRIS MD

R°0 5 2011

gistrar's Signature

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-	Exami	ner	Anne Arundel		ente	r	1		Location o	or Death		. 4	c. County Anne		unde1	
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Balt	permit. Page 1 ar Department of H Important: If iten any injury or oth		21. Signature of Funeral Service Lice	Λ							Mort					
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. Box 68760	the nayonal or Automing Prysician: The law requires that the death certificate be thin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physici mpleted filled in by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 🔲 Fetal	death 3	Ectopic pr Other (spe						23d, Dat Mor	e of delive nth	•	/ear
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Division of Vital Records,	io the hospital of Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the ft	al Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	d 28e. Place of Injui building, etc.	(Specify)					13	City or Tow	vn, State	9)		Route Numbe	er,
1	the nosp hin 24 hou the Funer upleted fill	Medical	only one) 3 Certifying Nu	ysician: To the best of r miner: On the basis of ex irse Practioner: To the b	amination.	and/or investi	gation in m	v opinion	death occ	curred at the	e time date a	nd place	aub bae	to the call	co(c) and man	ner stated.
	Vith Con		29b. Signature and title of certifier	Denta	η		29c. l	icense r	number	38		29d. Da	ate signed	(Month, D	31 20/	/
	2+1 W		39 Name and address of person who	alENTA	ath (Item 2	23a) (Type, Pr	. 1	ENS	Et	twy	ANNA	Pucc	, M	214	31201	
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11-02569

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State of Maryland / Department of Health and Mental Hygiene Shawn King, Sr. 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0046 hrs Medical Examiner SHAWN KING, SR. April 4, 2011 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Southern Maryland Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** oreign Hours Months Days MARCH 11,1973 Country) VIRGINIA Director 225-47-3267 38 1XM 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Y Yes 2 No BRANDYWINE MARYLAND PRINCE GEORGES 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
satt. If item 27 is marked other than "natural", or items 23a or 28a-f she rother trannatic event, the Medical Examiner must be notified at once 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 20613 15513 GIDEON GILPIN STREET ᅙ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X Married 1 Never Married Yes Specify: BLACK 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted College (1-4 or 5+) Elementary/Secondary (0-12) Itimore, MD 21215-0036 **EDUCATION** TEACHER YEARS 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EFFIE BELL MOORE KING ADOLPHUS KING Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15513 GIDEON GILPIN STREET, BRANDYWINE, MD 20613 TIFFANY W. KING / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State tment c SHILOH CHURCH CEMETERY APRIL 11,2011 BOYKINS, VIRGINIA 4 Donation 5 Other Specify: Baltin permit. 1 Departm 21 Annature of Funeral Service Licensee 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, LYDIA C. THORNTON JOHNSON MARYLAND 20640 M00583 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line (Medical Death a. Pulmonary Thromboembolism Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) b. Bilateral Deep Venous Thomboses Sequentially list conditions, Due to for as a consequence of: if any leading to immediate cause. Enter Underlying Cause Examiner c. Right Knee Injury (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical tending physician a UNPENDED AMENDED The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. β 2 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed' ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical of Vital B Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) Feb 9, 2011 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Suject injured knee UNKNOWN 1 Natural Division 1 ✓ Yes 2 No 5 Pending 2 🗹 Accident Investigation in by e Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 6035 Radio Station Road, La Plata, MD determined (Specify) Basketball court 4 __ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated etely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. April 4, 2011 30. Name and address of person who completed cause of death (Item 23a) KB8 Patricia Aronica-Pollak MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Parker Registra

DHMH 17 Rev 1/2001 **OCME 2006**

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Menth Physician/ Mildred H. Klink Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Allegany Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛣 F Months Days Hours 215-20-5770 87 Director September 28, 1923 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🗶 No Maryland Allegany Frostburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1799 Finzel Road Funeral 21532-U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herbert D. Swain Amanda Belle Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Klink 1057 Finzel Road 21532-Frostburg Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State **Emmanuel Methodist Cemetery** April 02, 2011 Frostburg Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Anoxic CACCA halopa disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury there sclentic -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last use as the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 4 ☐ Pregnam 9 ☐ Unknown 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstructive Pulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of certificate has autopsv page death? reamothers x 2 🗆 No 1 Yes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital 2 No Other: 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) မ 1, Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1XNatural work? 1 ☐ Yes 2 ☐ No 5 Pending after death.

Director: Aft
d in by the fur Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Homicide completed filled in by determined City or Town, State 24 hours a Funeral L Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F March 31, 2011 who completed cause of death (Item 23a) (Type, Print) 20 Douglas Ave., Lona coning, Med 21539

State

Registrar

arke

Registrar's Signature

^(ear) 2011

Please Type or Print in Black Indeline Isk Freure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician/ MA0530 04 200 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death Calvert Memorial Hospital-4th Floor Calvert Prince Frederick Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Funeral 1 🖾 M 2 🗆 F 0171371928 407-28-8873 KY **Director** 83 Usual Residence of Decedent or 28a-f show notified at 10d. inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🖾 No MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ural", or items 23a of Examiner must be Funeral 20639 United States 3121 Hunting Creek Road 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married X Yes Maryland 21215-0036 1 ☐ Yes 2 A No Specify: If Yes, Give Specify: "natural" 3 Widowed 4 Divorced Completed White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Real Estateand Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Appraiser Government Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Härriet Mutters Fred Kitchen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) O Box 87, Huntingtown, MD 20639 Betty Kitchen / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State Chesapeake Highland 04/08/2011 Port Republic, MD 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Lary, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has b I director, page 2 sh Hospital or Attending Physician: The law 24 hours after death.
Funeral Director: After this certificate has b autopsy performed? prosta 1 🗆 Yes 2 🗆 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔏 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 M Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c, License number 29d. Date signed (Month, Day, Year) မှ April 1, 2011 D0061783 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Trederick, mo HOSPITOU nung Choi 100 32. Registrar's Signature 31. Date filed (Month, Day, Ye APR 0 6 201 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month (Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death Montgomery 17809 Hidden Garden Lane Ashton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 0471171954 Washington, DC Director 212-64-0552 56 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Marvland Ashton Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 17809 Hidden Garden Lane 20861 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ner than "natural", or it t, the Medical Examine Black, White, etc ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) F.D.A. Scientist e 1 and 2 should be filed wit of Health and Mental Hygie If Item 27 is marked other or other traumatic event, IL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Nestor Joseph Kuchinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If Item 27 is any injury or other trau 17809 Hidden Garden Lane, Ashton, Maryland 20861 Nicole L. Wolanski/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Kalas Crematory 04/01/2011 Edgewater, Maryland 4 Donation Other (Specify) 21. Signatur f Funeral S 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd.,Edgewater, MD 21037 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failude. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ rate disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death the P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical director. 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) : After thi 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 \(\text{Yes} \) 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 🗀 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier VINTON M.D. MD037655 3/3////
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TRING Veytsman, MD. 110 TRUING Street Washington DC 20010 31. Date filed (Month, Day, Year) APR 0 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death March Physician/ 30^{Day} 2011 Harold Paul Kelly 11:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Montgomery General Hospital 01nev 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 90 yrs. 8. Date of Birth **Funeral** Social Security Number (Month, Day, Min. 1 X M 2 □ F 1920 Holvoke, Director 579-14-7005 June Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 United States 15115 Interlachen Drive #715 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc ve 1942-45 1 Never Married 2 Married Completed by Specify: Caucasian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Midowed 4 □ Divorced If Yes, Give Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Harold Paul Kelly Cynthia Giusta 1 and 2 should be Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14500 Gallant Fox Lane, Gaithersburg, MD 20878 Dennis P. Kelly, Son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Department of H Important: If ite any injury or otl 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Crematory 4/7/2011 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service-Licensee MO1102 KOLUL 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ SEPTIC disease or condition Medical resulting in death) Examiner BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jician and e burial-transit Examin CELLULITIS Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical attending p IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, CHF 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy RENAL FAILURE 2 12 No 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျ 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completed filled in by the funeral 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury work 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D59418 MARCH 31,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTGOMERY GENERAL HOSPITAL OLUYEMISI ADEWUNMI, MO 31. Date filed (Month, Day, Year, State APR 05 2011 Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Lee 9:53 PM April OI 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita Baltimore Hardor If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min Month, Day, Year 8-13-46 1 ☑ M 2 ☐ F Hours 218-52-7247 64 Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No Maryland Baltimore City 10e. Street and Number 10g. Citizen of What Country? Funeral 3909 6th st Apt 21225 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1 Yes 2 No 1966 If Yes, Give 1072 Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 1972 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bell Roofing Roofer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Mary Lee Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Lee/Wife 01 Franklin Ave. Brooklyn Park MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran 4 - 13 - 11Cheltenham MD 21. Signature / Funeral Service Livenses 22. Name and Address of Facility <u>Adams Funeral Home Pa.Aquasco MD 20608</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Musocardia disease or condition minutes Medical resulting in death) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury equence of) therosclerosi the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Year Dav 1 Yes 2 g been signed by the should be detached 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Rense Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s has performed Hupertension
25. Was cas referred to medical certificate 1 Yes 2 No Yes 2 No after death.

Director: After this certification of the funeral director, Be 26. Place of Death (Check only one) examiner? 1 X Yes Hospital Other: 2 🗌 No မ 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Medical 29a. Certifier 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier

Karen Stevenson, MD, Hanbor Hospital, 3001 South Hanover St., Baltimore, MD 21225

State
Registrar

APRO 2011

C2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

levensos

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year /3/2011 6:44 P William Daniel Lewis, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Berlin Worcester Atlantic General Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. MD Country) g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗷 M 2 🗆 F Months Days Hours Min. 12/23/1932 78 **Director** 220-28-1226 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No MD Worcester Bishopville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 10729 St. Martins Neck Rd. 21813 USA be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify: 3 🖁 Widowed 4 🗆 Divorced "natural", Completed Year or Dates. AF permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Town of Ocean City MD administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eba Daniel Lewis Ethel Virginia Tarr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Lewis (daughter) 11003 Gray's Corner Rd. #74 Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, XBurial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 4/7/2011 4 ☐ Donation 5 ☐ Other (Specify) Berlin, MD 1 Fury 21. Signaur 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lung disease or condition resulting in death) Medical Due to (or as a con-equence of): Examiner Sequentially list conditions, Examine If un, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day Yes 2 □ No is certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Preumonia. Records, 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an the Hospital or Attending Physician: The law autopsy performed Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1XI Natural injury 5 Pending Division 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO064120 and address of person who completed cause of death (Item 23a) (Type, Print) 12+1 HC Aut 9733 Healthway Drive Berlin MD 21811 Atif Zeeshah 31 Date filed (Month. Day, 32 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Villian

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 1.151 rowana 20KM MUNUM 7011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mesminste ZM If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth Date or Day, (Month, Day, 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Pennsylvania 1 M 2 X 160-20-7995 Director 84 June Usual Residence of Decedent or 28a-f show 10a. State 10h Count 10c. City, Town or Location 10d, Inside City Limits must be notified at Director Westminster Carroll 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21158 1026 Hughes Shop Road USA items death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 X No hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed white Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 and Mental Hyglene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Pharmacy Pharmacy Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Cora Harrison Walter Carney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1030 Hughes Shop Road, Westminster, MD 21158 Spencer L. Leckron, Sr., son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4/5/2011 Westminster, MD Meadow Branch Cen. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral, Westminster, MD 21157 Home 91 Willis Street, Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between O set and Death Immediate Cause (Final Siponnomic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) -transit Exam requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the burial physician Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death the a | Linknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confibute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an or Attending Physician: The law has page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes <u>م</u>| 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Inpatient Manner Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 295 - ner 30 we Sminster 31. Date liled (Month, Day, Year) 32. Red State Registrar

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No NITL Tracie L 21158 30. Name and address of person who completed cause of death-(Item 23a) (Typq, Print) Ryberg, D.O. Westmin strar's Signature 32. Reg 31. Date filed (Month. Day, Year) State Registrar **ORIGINAL**

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Joseph Larkin 2011 April 6:30p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 9988 Wamsley Court White Plains Charles If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 6. Sex 1 M 2 □ F Days 564-56-3661 Director December 12,1939 Delaware Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, If a Medical Evanings must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo MD Charles White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9988 Wamsley Court 20695 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ XNo Specify <u>Ş</u> White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Program Manager Federal Govt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph A. Larkin ၉ Sarah Larkin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mun Larkin/wife 9988 Wamsley Court, White Plains, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of h
Important: If he
any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 4/5/2011 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. M00945 St. Mary's Ave. La Plata, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ancel disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Year Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 **1** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. TNO 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7.B/C

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 06

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Liller Physician/ Lena Virginia 2011 8:10 A April 2, Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cumberland Golden Living Center Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral 92 1 M 2 XF West^{nt}Virginia 02/26/11919 220-34-1529 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Directo Cumberland Allegany MD 1 🗆 Yes 2 🛣 No 10e. Street and Number 10701 01d Johnson Road ŏ 10f. Zip Code 10g. Citizen of What Country? 21502 23a Funeral items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc and Mental Hygiene. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 X Widowed 4 □ Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life._DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Frances Elizabeth Ansel Spring 2 Wesley Lloyd permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print)
Barbara Liller/ Daughter 10 Miling odres (Front and Number of Burel, Royal Milber Pitan Tayn, Mile, Zip 21502 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 Donation 5 Other (Specify) MD Vet Cem @ Rocky Gap 04/05/2011 Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. Tur- of Funera Service 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Sater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Few Days Pnysician Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Alzheimer's Dementia Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending hours after death. neral Director: Aff d filled in by the fur Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) April 4, 2011 D46346 erson who completed cause of death (Item, 23a) (Type, Print)
N. D., 625 Kent Avenue, Cumberland, MD 32. Registrar's Signature State backs

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29^{Day} Physician/ March 201^{Year} Carolina Anna Lawson 7:20 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Bowie Woodward Estates 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar. 11, 1920 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 X F Months Country) Italy 436-60-4476 Director Vrs Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10h County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 14997 Health Center Dr., Apt. 20716 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Examiner Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give ithin 72 hours a er 1 Yes 2 X No Specify: Specify Completed 3 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) the Professor filed viii al Hycie other t Higher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F ပ permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Giuseppe Donadio Concetta Bartolomeo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12514 Rambling Lane, Bowie, MD John A. Lawson, II / Son 20715 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metro Crematory 3/31/2011 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signify of uneral S 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eag Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b, Was decedent pregnant 23d. Date of delivery Use Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ for in the past 12 months? Month Day the 1 ☐ Yes 2 2 2 9 ☐ Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an The law autopsy performed? this certificate 2 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Assulee 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director; After thi
completed filled in by the funeral or 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of injury 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural 5 Pending Accident Suicide Investigation
6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Optifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the I within 2 To the I only one 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mD 600

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed Month, Day, Year)

APR 0 1 2011

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ hnei 2 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** D UM erela Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 08/06/1933 206 26 7885 77 Director PAUsual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Howard Ellicott City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3801 Chatham Road 21042 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2 Married 1

Yes 2 □ No
If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 - Widowed 4 - Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Mathematical Statistician Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Lechner Margaret Sauery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Ruppel/Daughter 314 Barnes Mill Rd. Richmond, KY 40475 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 🖺 Burial 2 🗌 Cremation 3 🗌 Removal from State Crownsville Vet. Cem. 4-11-2011 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ INTIACIANIA disease or conditi-resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to tur as a consequence of The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi DUMA that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Director: After this certificate has autopsy perform Hospital or Attending Physician: completed filled in by the funeral director, To Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury work? Natural Division 2 🗌 No death. Investigation 6 Could not be Accident Suicide Suicide
Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 □ only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29c. License number ess of person who completed cause of death (Item 23a) (Type (Print) 11 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

		For State	State of M		d / Depa	artment of l tificate of l	Health and	Mental Hy	giene	e. 12704		
Physicia		1. Decedent's Name (First, Middle, RUTH ELEINE MI				incate of t	Jeaur	2. Date of Dea		3. Time of Death 5:21A M		
Medic Examin		4a. Facility Name (if not institution, give street and number) SOUTHERN MARYLAND HOSPITAL CENTER				4b. City, Town, or Location of Death CLINTON			4c. County of Death PRINCE GEORGES			
Funeral Director		5. Social Security Number 578–40–7526	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt OCT 3		Birthplace (State or Foreign				
ryland I-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County	OPODGEG.	1	, Town or Loc					10d. Inside City Limits 1 √ Yes 2 □ No		
vith the Ma 23a or 28a st be notii	Funeral Director	MD PRINCE 10e. Street and Number 4006 24th AVEN	GEORGES UE		IENFLE	10f. Zip Code 207	48		10g. Citizen of What	Country?		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mehrial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ N N F Yes, Give Year or Dates.			If	Yes, specify Cuba	s Decedent of Hispanic Origin? (Specify Yes or Noss, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Specify: BLACK					
within 72 hou /giene. ner than "natu t, the Medical	e Completed	15. Decedent (Specify only highes Elementary/Seconday (0-12) 12	's Education t grade completed) College (1-4 or 5	5+)	(Give k life. DC	ent's Usual Occup kind of work done of NOT use retired) TIONIST		king	16b. Kind of Busine	ss Industry		
d be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, La UNKNOWN UNKNO						ame (First, Middle, Maiden Surname) EYES DANIELS				
nd 2 shoul saith and I n 27 is m		19a. Informant's Name/Relationshi MADGE MILES	p (Type, Print)						; City or Town, State, S ,MD 2074			
Page 1 ar nent of Hk ant: If iter ıry or oth		20a. Method of Disposition 1 Neurial 2 Cremation : 4 Donation 5 Other (Sp		ce	emetery, crem	sition (Name of natory or other place EMETERY	e) APRI	Date L 9, 2011	20c. Location - City SUITLAND	or Town, State MARYLAND		
permit. Departr Import any inji		21. Signature of Funeral Service Co. THORNI	ON JOHNSON MOC	583	22	THORNTON 3439 LIV	FUNERAL INGSTON	HOME, PAROAD, IN	A DIAN HEAD,	, MD 20640		
Physician/ Medical		23a. Part 1. Enter the disease, or o shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line	е.						Approximate Interval Between Onset and Death		
Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a Due to (or a) D	a conseque	nce of):	ory F	perte	nsrov	1			
be executed sician and burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	C C 0	ido	815						
eath certificate b attending physic I for use as the b	/Medic	IF FEMALE:	d	of pursuan					1			
or Attending Physician: The law requires that the death certificate after death. Director: After this certificate has been signed by the attending physin by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 4 Pregnant a	2 Fetal	death 3 🗌	Ectopic pregnand Other (specify)	ey		23d. Date of Month	delivery Day Year		
requires that the de been signed by the should be detached	ρ	23e. Did tobacco use contribute to the c										
he law req tte has bee bage 2 shor	Completed							24a. Was a autop perfor	med? prior to death	autopsy findings available to completion of cause of ? Yes 2 \sum No		
Physician: The lav r this certificate has ral director, page 2	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	0 D F	-D/O 1	Oth	ace of Death (Chec	ck only one)				
ending Phy ath. r: After this ne funeral c		1			nt 2 ER/Outpatient 3 DOA 4 Nursing 28b. Time of 28c. Injury at			ng Home 5 Residence 6 Other (Sp. 28d. Describe how injury occurred		ecity)		
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funer		3 Suicide 6 Could not determine			ne, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number or i n, State)	Rural Route Number,		
To the Hospital Within 24 hours To the Funeral I completed filled	Medical	(Check 2 Medical Exonly one) 3 Certifying	Physician: To the best of aminer: On the basis of edurse Practioner: To the	xamination	and/or investi	gation, in my opinio	on, death occurred a	at the time, date a	nd place, and due to the	ne cause(s) and manner stated.		
To with		29b. Signature and title of confier	1			29c. License	9635		29d. Date signed (Mo	nth/Day, Year)		
85_		Frank Lich	no completed cause of di	AYT	503	rint) Sulla	HSAd	. Chr	iton, mo	120735		
State Registra	٠ ا	31. Date filed (Month, Day, Year) APR 0 7 20	11 Centra	ar's Signatu	Sav	اري			,			

11-02768 Robert Lee Myers Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ореп Lee Мує	318	State of Maryland / Department of State of Maryland / Department of Certificate of Registrar			. No.	12/00
Physic I⊶ical Exam		1. Decedent's Name (First, Middle,Last) Robert Lee Myers		2. Date of Death Month April 11, 20	Day Year	3. Time of Death 1220 hrs
		4a. Facility Name (if not institution, give street and number) 7311 Grove Road	4b. City, Town, or Location of Death Frederick		4c. County of Deat Frederick	<u> </u>
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs		(MM/DD/YYYY) 9. Bi	
Director		219-66-4840 1X M 2 F 54 Y	rs. Months Days Hours Min	Jan 8,	1957	ountrMaryland
w any		10a. State 10b. County 10c. City, Town or Loc Maryland Frederick Adams to				10d. Inside City Limits
Aaryland 28a-f show Lat once	Director	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Cou	1 Yes 2 X No
th the M 23a or 2 notified		5709 Mountville Road	21710		U.S.A.	
death wi r items	Funeral		Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		White, etc.	ican Indian, Black,
ns after n ral", o miner p	<u>چ</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify: ent's Usual Occupation (Give kind of v	vork done	Specify: WN 16b. Kind of Business/	ite
36 in 72 hou hau "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use reti ident/Owner			ection Co
5-0036 iled within 72 ho Hygiene. I other than "na the Medical Ex		17. Father's Name (First, Middle, Last)	18.Mother's Name		aiden Surname)	
MD 21215-0036 1.2 should be filed within 72 hours after death with the Maryland th and Mental Hyggiene. 27 is marked other than "natural", or items 23a or 28s-f she amaric event, the Medical Examiner must be notified at once	o Be	Lewis Calvin Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	Georgia		Potts er, City or Town, State	e, Zip Code)
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental I tant: If item 27 is marked or other tranmatic event,	_		Mountville Rd, A		, Maryland	
Baltimore, ME permit. Pages 1 and 2 s Department of Health an Important: If item 27 injury or other tramm		1 X Rupid 2 Comption 2 Removed from State Crematory or				
Baltin permit. 1 Departm Importa	j	21. Signature of Funeral Service Ocensee 22.	Name and Address of Facility Keeney & Basford	P.A. Fun	eral Home	
Physician		Part I. Enter re disease, or complications that caused the death. Do not enter failure. List rily one cause on each line.	Ob E Church St F the mode of dying, such as cardiac o	rederick r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Morphine And Quetia Due to (or as a consequence of):	pine Intoxication			Death
	<u>-</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				-
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
60, tte be executed hysician and e burial - transit		d.	***			
. 68760, certificate be executed anding physician and ise as the burial - trans	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	g915 5-13-11 sm		23d. Date of deliver	/
Box 687: c death certifice the attending picked for use as the	Physiclan/I	Pregnant at time of death 5	etal death 3 Ectopic pregna	incy	Month	Day Year
		1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
S, P.O. luires that the signed by all be detach	ed by				2 No 3 Pro	
cord law req e has bee	Completed			24a. Was an autopsy perform	prior to ed? death?	topsy findings available completion of cause of
zal Re inn: Th certificat	Be Co	25. Was case referred to medical examiner?	26.Place of Death (Check			
Division of Vital Records, tal or Attending Physician: The law requirers after deart. After this certificate has been sited in by the funeral director, page 2 should be	မှ	1 Yes 2 No Prospital 1 Inpatient 2 ER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of			esidence 6 🗸 Othe minjury occurred	r: Scene
Sion Attendin death. sctor: A	catior	Natural 5 Pending Pending Accident Pending Investigation Fd 4-11-11 Fd 12:	00 pm 1 Yes 2 X No	prescrip	tion medi	
Divisor of the pital or of the sure after cral Direction of the pital birth of the pital of the	Certification:	3 Suicide 4 Homicide 6 Could not be determined Could not be determined Could not be determined (Specify) Residence	eet, factory, office building, etc.	or Town, Sta	te) 7311 Gro	ral Route Number, City ve Rd.
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Foueral Director: After this certifi completely filled in by the funeral director,	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occore) 2 Medical Examiner:On the basis of examination and/or investig	urred at the time, date and place, and ation, in my opinion, death occurred a	due to the cause(t the time, date an	s) and manner as stated by and manner as stated by and due to the	ed. e cause(s)
To rou	Med	and manner stated. 29b. Signature and title of certifier	29c. License number	1	29d. Date signed (Mo	
-		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		April 13, 2011 	
5		Pamela E. Southall, MD Assistant Medical Examiner 1	11 Penn Street, Baltimore, N	MD 21201		
St	tate	31. Date filed (Month Day, Year) 2011 32/Registrar's Signature	well			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2, 2011 Stella Malinowsky McCorkle 3:05 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Somerford House Frederick 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 ☐ M 2★XF Oct 24, Year 921 Months Days Hours Min. 89 Pennsylvania Director 184-18-2461 Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 USA 2100 Whittier Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 Ves Give 1 ☐ Yes ŽXX No Specify: 3 Widowed 4 ☐ Divorced white Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Macar William Malinowsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7839 Old Receiver Road, Frederick, Maryland 21702 Tammy McCorkle - daughter Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 4-4-2011 Frederick, Maryland 22. Name and Address of Facility Signature of Funeral Service Lizensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Heart Poilure Onset and Death Immediate Cause (Final con ges Physician/ disease or condition Medical resulting in death) or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 5 Other (specify) Pregnant at time of death ed by the a detached f 1 Yes 2 9 Unknown g Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an page 2 autopsy this certificate 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Assisted Living 2 No 1 Yes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Watural injury 5 Pending Accident 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signati 29d. Date signed (Month, Day, Year, D1062223 4/4/2011

Box 68760

P.O.

Division of Vital

State Registrar

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) LAYEEN ROLALUM 196 TJULIUE, 32. Registrar's Signature

PREPENCE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4 201^Y1 Elizabeth Erma Merriman 1:08 P M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2X F *M7737*4926 723-14-7868 84 Maryland **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes X No MD Frederick Knoxville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3651 Petersville Road 21758 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Housewife permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Lewis A. House Elizabeth May Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 85, Brunswick MD. Michael A Duncan, Son 21716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State St. Marks Cemetery 4/4/2011 4 Donation 5 Other (Specify) Knoxville MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BulmaAn John T Williams Funeral Home, Brunswick MD. 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Infarction Myocardial disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, 1 Yes 2 No 3 Probably 4 Wonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 2 No 1 Yes Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one e of certifier 29b. Signature 30. Name and address of per completed cause of death (Item 23a) (Type, Print) MID State Registrar

DHMH 17 Rev 7/2009

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O 4 Physician/ 2011 06 argeret L. Medical 4a. Facility Name front institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert Memorial Hospital Calvert 8. Date of Birth (Month, Day, Year) April 7, 1927 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Country) Maryland 84 Director 212-40-0062 April Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Tyes 2 No Maryland Bushwood St. Mary's 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral USA 20618 22209 Coltons Point Road death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? Black, White, etc. "natural", or ģ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nellie Eleanor Farrell permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Joseph Ashby Quade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20659 28002 Steeple Court Mechanicsville, Maryland Dennis Morgan/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 14, cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bushwood, Maryland Sacred Heart Cemetery Supplure of Funeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home P.O. Box 270 Leonardtown, Maryland 20650 taroline 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHF disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last -burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🖾 No Month Day Year ed by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate funeral director, pag 1 Yes 2 No ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 No 은 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending work hours a er death. 1 Tes 2 🗌 No within 24 hours are death

To the Funeral Director: A
completed filled by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, DO061783 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chang Bae Choi, 100 Hospital Road Prince Frederick, Maryland 20678

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2011 2:34 p.m. Ignacio Anthony Medellin April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Solomons Nursing Center Solomons Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours Min. (Month, Day, Year 04/15/192 83 Director 201-16-9593 Texas Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and If if item 27 is marked of other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or orther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits irector 10c. City, Town or Location 1 Tes 2 X No Maryland Calvert Solomons Ö 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 13325 Dowell Road 20688 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. rmed Fo If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Defense Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ignacio L. Medellin Isabel Gutierez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine M. Peck/Daughter 12465 H.G. Truman Road, Lusby, MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 04/15/2011 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ erebrovas cular Syendisease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ro nany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence on i'clo eta The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown the page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 🗌 No 1 🗌 Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work?
1 Yes 5 Pending 2 🗌 No Accident Investigation

Box 68760 Division of Vital Records, P.O. the completed filled in by

Medellin

Ignacio the Hospital or Attending Physician: within 2 To the I

Suicide

4 Homicide

29a. Certifier (Check

Could not be

	29b. Signature and title of certifier han les Bennett MS	29c. License number 025 i 56	29d. Date signed (Month, Day, Year) April 14, 2011
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Benneth M.D. 11845	Trueman Road	Lusby, MD 20657
tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	N.	

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#23apenMD, 4/5/11: BWV.McCo Certificate of Death 2. Date of Death March 30 Day 2011 Physician/ Mary Ellen Meng 2:45 рΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 17305 Guttenberg Court 01ney Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last hirthday) Hours Min Nov. Pay Year 1951 Country) 1 M 2 XF 59 D.C. Director 220-60-5586 Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 01ney 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17305 Guttenberg Court 20832 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Montgomery County College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Washington Purdy Phoebe Jeanette Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin R. Meng/Husband 17305 Guttenberg Court, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 12 Burial 2 Cremation 3 Removal from State April 2011 Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring,MD 22. Name and Address of Facility. Francis J. Collins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Service Licensee MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Leiomyosarcoma disease or condition years Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): death certificate be executed Causa (Diseasa or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Medical Box 68760 attending p for use as t IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Dav Year Pregnant at time of death ed by the a detached t q Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2X☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page performed? 1 Yes 2 No Yes 2 🔣 No Physician: Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛂 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🖺 Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pendina within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No ☐ Accident☐ Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifler 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D43083 10 March 31, 2011 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Rockville Pike, Suite #300, Rockville, MD 20850

Registrar DHMH 17 Rev 7/2009

State

George A. Sotos, MD

APR 01 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6500 Woodstream Drive Lanham Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country PA Months Days Hours Min. Aug. 6, 1924 1 M 2 TKF 86 Director 195-20-4180 Usual Residence of Decedent than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location death with the Maryland Director 1 Yes 2 XNo MD Prince George's Lanham 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 6500 Woodstream Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after Specify: White 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working th and Mental Hygiene. 27 is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> Own Home Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ pe. William Franklin Rinehimer Bertha E. Deets permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Mahon/Husband 6500 Woodstream Drive, Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town, State cemetery, crematory or other place) 1X Burial/ Creynation 3 🗆 By from State Gate of Heaven Cemetery April 4 Donation 5 Other (Specify Silver Spring,MD Francis J. Collins Funeral Home 500 University Blvd. W., Silver vid Lice Fune Inc. Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burian Physician/Medical Box 68760 the SS IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death No 9 Unknown g Unknew Division of Vital Records, P.O. page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performa certificate 1 Yes 2 No 2 Yes To the Funeral Director; Atter this century, completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: No Other: မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work after death. 1 Yes 2 No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nursep cationer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature completed cause of death (Item rgital Dr. Suit McVey 31. Date filed (Month, Day State APR 01 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . Day 2011 Physician/ March 30, 5:05 a Emily Hanna Murray Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Gilchrist Hospice Center 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 6. Sex Age (In yrs. last birthday) Month, Day, July 21 Days Min 1 M 2 M 79 Pennsylvania 147-24-6314 **Director** 1931 Usual Residence of Deceden or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Timonium Baltimore 1 ☐ Yes 2 X No Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21093 **USA** 12261 Roundwood Road Apt 214 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Art Work Painter/Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rebecca Sponsler John R. Hanna 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46235 Riverland Road, Sterling, VA 20165 John H. Murray, son Baltimore, 20b. Place of Disposition (Name of Scanding crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 3/31/2011 Winfield, MD 4 Donation 5 Other (Specify) Carroll Crematory 21. Signature of Funeral Service Licenses Myers-Durboraw Funeral Home Willis Street, Westminster, MD 21157 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 5 Other (specify) signed by the a 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy page perform 1 ☐ Yes 2 M No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only on 29d. Date signed (Month, Day, Year) WIL 0 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WES 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician/ Maqdalena Major 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Baltimore Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours Mir 1 M 2 St F **Director** 383-18-5353 89 /17/192 MI Usual Residence of Decedent 28a-f show aţ 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Examiner must be notified MD Baltimore Towson 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 125 A Versailles Circle 21204 death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 ò 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. V within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 √2 No Specify. "natural", Specify: white 3 Widowed 4 Divorced Completed WWII Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the secretary Baltimore City Court Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H
f item 27 is marked ot
r other traumatic ever ည Daniel Oanea Elizabeth Suchu permit. Page 1 and 2 should Department of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau David Hayden, nephew P.O. Box 68 Upperco, MD 21155 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Carroll Cremation : 3/29/2011 4 Donation 5 Other (Specify) Hampstead, MD Signature of Funeral Service Licensee 22. Name and Address of Facility M00741 Eline Funeral Home 934 S. Main Street, Hampstead, 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHRONICOBSTRUCTIVE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence or, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 signed by the attending page as detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery Ectopic pregnancy in the past 12 month 3 ☐ Ectopic pregna 5 ☐ Other (specify) Month Day Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? 2 Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? certificate 2 No 1 🗌 Yes Yes 25. Was case referred to Jedical director. Be 26. Place of Death (Check only one) examiner' Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work 1 Tes 2 🗀 No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi WIL 5+1VA 30 Name and ddress of person who completed car 31. Date filed (Month State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	lease			id / Dep	artment of	Health and I		giene	le.	
		Registrar				Ce	rtificate of	Death	Ť	Reg. No U	1 1 6 1 1 6	
Physicia Medic		1. Decedent's Name (First, N Harry		Jo	hn	Мо	Gowan		2. Date of Dea		3. Time of Death	
Examin	er	4a. Facility Name (if not instit Western MD R				nter		or Location of Death mberland	1	4c. County of I	Death legany	
Funeral Director		5. Social Security Number 212-16-8317 Usual Residence of Deceder		X X M 2 □ F	7. Age (In yrs. I 90	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 01/02/	Year)	Birthplace (State or Foreign Country) Maryland	
aryland ka-f show ified at	ector	10a. State 10b. Co		gany	10c. Cit	y, Town or Lo	ocation Cumber	land			10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
with the N 23a or 28 1st be not	Funeral Director	10e. Street and Number 36 Memoria					10f. Zip Code	21502		10g. Citizen of Wha		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	É	11. Marital Status 1 Never Married 2 3 X Widowed 4 Divo	Married	12. Was Deced Armed Ford 1 X Yes If Yes, Give Year or Dat	ces? 2 □ No 19	43-		Hispanic Origin? (Sp an, Mexican, Puerto Specify:			American Indian, Vhite, etc. White	
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ld be filed Mental Hy arked oth atic event	To Be	17. Father's Name <i>(First, Mid</i> Martin		ewey	Me	Gowan		18. Mother's Nar Charlot	ne (First, Middle, 1 te Aug	Maiden Sumame) gusta !	Hillen	
nd 2 shou ealth and n 27 is m		19a. Informant's Name/Relate Sharon L. No.			hter	19b. Maili 8857	ing Address (Street Pleasant	and Number or Rui t Valley	ral Route Number, Road, St	City or Town, State Cewartstor	, Zip Code) Nn, PA 17363	
Page 1 ar ment of Hi ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Crema 4 Donation 5 Otl			State	emetery, cre nberla		tory 03/2		20c. Location - Cit	and, MD	
permit. Departi Import any inj		21. Signature of Funeral Ser	rice Vicense	in						ly Funera land, MD		
Physician/		23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition	e, or compli List only one	cations that ca cause on eac	aused the deat h line.	h. Do not ent		ng, such as cardiac		est,	Approximate Interval Between Onset/and Death	
Medical Examiner	_	resulting in death) Sequentially list conditions,	f.	Due to (c	r as a/consequ	uence of):		- O			7	
be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	1)	r as a consequ							
cate be e physicial the buri	edical		L	i								
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2:		irth 2 🔲 Feta ant at time of o	aldeath 3	☐ Ectopic pregnan☐ Other (specify) _	су		23d. Date o Month	f delivery Day Year	
uires that the signed by all do be detact	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 X No 3								te to the cause of death?		
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an: T	BeC	25. Was case referred to med examiner?	lical				26. P	lace of Death (Chec		Pal NO IL	165 2 100	
nysic nis ce direc	2	1 Yes 2-1 No	Ĥ	ospital:	npatient 2 🗌	ER/Outpatie	nt 3 🗆 DOA Oth	ner: 4 Nursing H	ome 5 Reside	ence 6 Other (S	pecify)	
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the Hosp hin 24 hou the Funer ripleted fil	Medical	(Check 2 ☐ Medi only one) 3 ☐ Certi	cal Examin Tying Nurse	er: On the basis	s of examination	n and/or inves	stigation, in my opini death occurred at the	ion, death occurred a ne time, date and pla	at the time, date ar ice, and due to the	cause(s) and manne	the cause(s) and manner stated. er as stated.	
2+/,		29b. Signature and title of ce		tur			29c. Licens	0 0 3 3 2 6		29d Date signed (M Marreh	onth, Day, Year) , 29, 2011	
MLS		30. Name and address of per Sunil K.	Gupta	mpleted cause	, 625	Kent	Avenue,	Cumberlan	d, MD 2	1502		
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pε	er FD, (07/1, Allegany (- State Registrar	Co. State of M		ertificate of			Reg. N2 0	12715
	Dhusisia		1. Decedent's Name (First, Middle, L					2. Date of Dea		3. Time of Death
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	Examin		4a. Facility Name (if not institution, g Western MD Regio	nal Medical		Cu	or Location of Death mberland		4c. County o	Allegany
	Funeral Director		218 -32- 0062		ge (In yrs. last birthday, 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 12/04/	, Year)	9. Birthplace (State or Foreign Country) Maryland
	and show lat	5	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
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	with the s 23a or ust be n	Funeral Director	10e. Street and Number 108 Oldtown I	Road		10f. Zip Code 2	1502		10g. Citizen of W	/hat Country? USA
ဖွ	ter death , or items iminer m	by Fur	11. Marital Status 1 ☐ Never Married 2 💢 Marrie		Ever in U.S. 13	. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black	- American Indian, k, White, etc.
9	ours af tural" al Exa	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.					Specify:	White
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Maryland	d be filed Jental Hy Irked oth	To Be	17. Father's Name (First, Middle, Las William	lsaac	Ma	ıuzy	18. Mother's Nam Sadie		Maiden Surname) Tern	Walton
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Sadie F. Scott		19b. Mai 1380	ling Address (Street) 6 Black 1	and Number or Rura Valley Roa	ad, NE,	; City or Town, Sta Flintsto	ate, Zip Code) one, MD 21530
Baltimore,	Page 1 ament of Hant. If ite		20a. Method of Disposition 1		I.O.O.F.	ematory or other pla Cemetery	o3/3		Flintst	
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Lice	insee			ess of Facility Ada cur Street			al Home, P.A. D 21502
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-	Examiner	ř	Sequentially list conditions,	b	a consequence of):					
	outed nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that Initiated events	С.	a consequence of):					
90	te be exer hysician a he burial-f	dical E	resulting in death) Last	d.	a consequence of):					
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23d. Date Mon	e of delivery hth Day Year
s, P.O.	ires that th signed by d be detac	d by PF						23e. Did tobacco use contribute to the cause of 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎾		
Division of Vital Records,	e has beer ge 2 shou	omplete						24a. Was a autop	rmed? pi	Vere autopsy findings available rior to completion of cause of eath?
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<u>Xit</u>	hysici nis cer I direc	To Be	examiner? 1 Yes 2 No	Hospital: 1 🗌 Inpat		ent 3 ☐ DOA Oth	ner: 4 Nursing Ho	ome 5 🗆 Resid	lence 6 🗆 Other	r (Specify)
on of	nding Pl ath. r: After th e funera	icate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of inju (Month, Da	ury 28b. Time injury injury	wor		28d. Describe h	ow injury occurred	d
Divisio	al or Atte s after de al Directo ed in by th	I Certif	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determina	28e. Place of Inj	jury - At home, farm, s cc. (Spec <i>ify)</i>	treet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
_	he Hospit in 24 hour he Funera pleted fille	Medical Certificate:	(Check 2 Medical Exa	hysician: To the best of miner: On the basis of e urse Practioner: To the	examination and/or inve	estigation, in my opin	ion, death occurred a	t the time, date a	nd place, and due	to the cause(s) and manner stated.
	1/2		29b. Signature and title of certifier	done		29c. Licens	se number 3 9 8 1		_	(Month, Day, Year) 8 - 2011
	nal		30. Name and address of person what Jerry Adams, M		death (Item 23a) (Type O Willowbr	Print)			21502	V
	Sta Registr	te	31. Date filed (Month 89, 2011	32. Registr	rar's Signature					

amend #1 State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) McManimon McManimon 2. Date of Death 3. Time of Death Physician/ April ^{Day} 2011 Anita 8:50 P. M Marjorie 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Frederick Calvert 4559 Sixes Road . Social Security Number 8. Date of Birth (Month, Day, Ye July 20, 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Year 193<u>3</u> 1 M 2 XF 475-34-5994 Minnesota Director Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arment of Heatht and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director St. Leonard Calvert Prince Frederick MD 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4559 Sixes Road 5821 Valley Drive -20678Funeral 20685 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Universities Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Peter Rye Marqit Rye 19**582** hg **Waddley**et **Drive: St**wal **Leonard: MD** Town**20685**5 code; 4559 Sixes Road, Prince Frederick, MD 20678 19a. Informant's Name/Relationship (Type, Print) Paul R. McManimon/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State George Common Williams ty Medical Center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Juneral Service Licenses /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimer's Physician/ disease or condition no Hears Medical resulting in death) Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of and I-transit requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 12 9 Unknown 9 Unknown been signed by the should be detached P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law Jas performed? Yes 2 14 No 2 🗆 No 1 Yes 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) examiner? 2 🖾 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ဂ္ Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier harles W. Bennett M.D. 2KW 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Bennett M.D., 11845 Trueman Road hanles W. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2011 APROG Registrar Darke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Betty Margaret Moore 201] 12:50 a^M April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 623 Charles Street Perryville Cecil Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Pennsylvania 220-22-2260 1 □ M 2 🂢 F 83 Director Yrs Ĭ928 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director Maryland Cecil Perryville 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21903 U.S.A. 623 Charles Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Susquehanna Metal Box Company (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)
Eight Years College (1-4 or 5+) Machinist Havre de Grace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Earl H. Welty, Sr. Mabel Newcomer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hope L. Russell (daughter) P.O. Box 261, Perryville, Maryland 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Harrord Memorial 04/06/11 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <u>Gardens</u> 21. Signature of Funeral Service Lice 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications the beaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, NUMPL disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injured a control of the con Examine and -transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last consequence of) attending physician of for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 nonths?
1 Yes 2 No Day 5 Other (specify) Month Year Yes 2 signed by the sid be detached f Nο Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown been signature Were autopsy findings available 24a. Was an cate has page 2 s prior to completion of cause of death?

1 Yes 2 No autopsy After this certificate funeral director, pag 25. Was case referred t examiner? 26. Place of Death (Check only one) Be Hospital 2 No Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes ithin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one ire and title of certifier 29b. Signat 29c. License numbe 29d. Date signed (Month, Day, Year, 5 of person who completed cause of death (Item 23a) (Type, 32. Registrar's State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 26Day March 2017 04:33 PM Hewitt W. Maus, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. . Social Security Number 6. Sex Age (In yrs, last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours Min. 1070371939 Washington, D.C Director 578-52-6635 71 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔁 No Edgewater Anne Arundel Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 21037 1501 Warfield Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2 📆 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Carpeting Manager Bergmanns Cleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Mildred Duvall Hewitt W. Maus, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1501 Warfield Road, Edgewater, Maryland 21037 Patricia Maus/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 04/01/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit George F. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 2**X** No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this d in by the funeral di 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direct Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H58097 03/29/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 129 Lubrano Drive, Suite 100, Annapolis, Maryland 21401 Lyn Nguyen Dea, 31. Date filed (Mon Registrar's Signatu State R 01 2011 Registrar

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	Physicia Medi		State Registrar 1. Decedent's Name (First, Middle, Ruth Melser	, Last)		Cer	tificate of L	Death	2. Date of Dea April (1 Year	3. Time of 9:15		
ز	Examir		4a. Facility Name (if not institution, 4 Bouldercrest	give street and numbe Court	r)		4b. City Town or Rockvill	Location of Deat		Montg				
	Funeral Director		153-34-9338	6. Sex 1 □ M 2 🗓 F	Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		19,1946	g. Birti New	hplace (State or untry) ersey	Foreign	
	Maryland 28a-f show otified at	Director	Usual Residence of Decedent 10a. State											
,	with the s 23a or 3 ust be no	Funeral Di	10e. Street and Number 4 Bouldercrest	Court			10f. Zip Code 20850		10g. Citizen of USA	of What Country?				
980	rs after death rral", or items Examiner m	چ ک	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedel Armed Force 1 ☐ Yes 2 If Yes, Give Year or Dates	s? X No	11	Was Decedent of Hi f Yes, specify Cuba □ Yes 2X No	n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	Bla	ce - Amer ack, White y: Whi			
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Deceden (Specify only highes Elementary/Seconday (0-12)	t's Education st grade completed) College (1-4 o	or 5+)	(Give I life. Do	lent's Usual Occupa kind of work done of O NOT use retired) TOUT G	during most of wo		16b. Kind of Business Industry Tourism and Hospi			ality	
Maryland	snould be filed in and Mental Hy, and marked oth raumatic event.	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)											
, Mary	a 2 should saith and N n 27 is ma		19a Informant's Name/Relationship (Type, Print), Allen Melser - Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z 4 Bouldercrest Court Rockville, MD 2085)											
Baltimore,	t. Page 1 ar tment of Ho rtant: If iter njury or oth		20a. Method of Disposition 1											
配	Deparation of the concernation of the concerna	(i, i)	21. Signature of Funeral Service Li	MOO MOO	910		. Name and Addres						D2085	
	nysician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ovarian Cancer Due to (or as a consequence of):											
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. Box 687	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No g ☐ Unknown			ate of deli	very Day Ye	ear						
ds, P.O	en signed by	ed by PI	Part II. Other significant condition	ns contributing to death	but not resu	Iting in the ur	nderlying cause giv	en in Part I.				the cause of dea		
Recor	icate has be	Completed by	05 W	,					24a. Was a autops perfor 1 □ Yes	sy	prior to co death?	opsy findings av ompletion of ca 2 No	ailable use of	
· Vita	his certil	To B	25. Was case referred to medical examiner? 1 Yes No		atient 2 🗆 E		Otho	ace of Death <i>(Che</i> er: 4 Nursing F	ck only one) Iome 5 🗓 Reside	ence 6 🗆 Oth	ier (Specit	fy)		
on o	eath. or: After he funer	Certificate:	27. Manner of Death 1	ation		28b. Time of injury	28c. Injury work? M 1 1	rat ? Yes 2 □ No	28d. Describe ha	w injury occurr	red			
DIVISI	rs after d al Direct ed in by 1		3	28e. Place of I	njury - At hom etc. <i>(Sp</i> ec <i>ify)</i>	ne, farm, stre	et, factory, office		28f. Location (St City or Town		er or Rura	al Route Numbe	r,	
e Hosni	n 24 hou ne Funer pleted fill	Medical	(Check 2 Medical Ex	Physician: To the best caminer: On the basis o Nurse Fractioner: To the	f examination :	and/or investi	gation, in my opiniou	n. death occurred	at the time, date an	d place, and du	ie to the ca	ause(s) and mani	ner stated.	
P _E	with of Lot		29b. Signature and title of certifier	n. Hagg			29c. License D32407	The same of the sa	2	9d. Date signe	d (Month,	Day, Year)		
			30. Name and address of person w Josepth M. Hagge	ho completed cause of rty MD 970	death (Item 2 7 Medi	23a) (Type, Pr .cal CT	R DR. Ro	ckville,	MD 2085	0				
	Stat Registra	٠,	31. Date filed <i>(Month, Day, Year)</i> APR 0 5 20	2. Regis	trar's Signatu	far	w							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Leroy Vincent McCusker DOLL Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany Western Maryland Health System Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F Months Days Hours 07/18/1935 **Director** 75 214-34-9285 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits notified at 10c. City. Town or Location Director 1 Yes 2 No MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? traumatic event, the Medical Examiner must be Completed by Funeral USA 3120 Western Pike 21750 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, med Forces?

Yes 2 \sum No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 X Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automotive Elementary/Seconday (0-12) College (1-4 or 5+) 12 Service Station Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William A. McCusker Hazel R. Munson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Heath Important: If item 27 any injury or other tr once. Ronald L. McCusker/Son 6389 Thompson Road Needmore, PA 17238 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 104/15/2011 Smithsburg, MD Signature of Funeral Service Licens 22. Name and Address of Facility 141 West Main Street 1/21/M00260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List are one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Cerebrousscular acule Jeck Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) Month Day Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No Yes 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: ျ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After iniury 1 Natural 5 Pending after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral I 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one)

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vikramaditya Poonai, M.D. 924 Seton Drive Cumberland, MD 21502

Registrar's Signature

29c. License number

29d. Date signed (Month. Day, Year,

14,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 30, Day 2011 Year Physician/ Dorothy Norland 6:20 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Village Prince George's Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Hours Min. $\text{March}^{(Month, Day)}$ 89 Director 238-26-5455 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No MD Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 3114 Gracefield Road, Apt. 417 20904 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. ğ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 White 1 Yes 2 No Specify. 3 🗌 Widowed 4 🗆 Divorced Specify: "natural" Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked ot ပ Brodie L. Martin, Julia Hooks 19a. Informant's Name/Relationship (Type, Print)
Selmer S. Norland/Husband 19b. Mailing Address (Street and Number or Rural Route Number. City, or Town, State, Zip Code) 3114 Gracefield Road, #417, Silver Spring, MD 20904 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arington National Cametery Date 20c. Location - City or Town, State 19, 1 Burial 2 Cremation 3 Removal from State Arlington, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. od the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End-Stage Alzheimer's Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) y the attending physician and ached for use as the burial-tr-nsit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Yes 2 X No ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Atrial Fibrillation, Hypertension, Osteoarthritis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy perform Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☑ Natural work? 5 \square Pending Accident Investigation 6 Could not be Suicide ☐ Suicide ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State 0 4 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2011 APRIL 12:30A M Physician/ NEWTON MARY ANITA Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** CHARLES LA PLATA GENESIS LA PLATA CENTER 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number SEP. 20, 1934 **Funeral** Days Hours Min. WASH., DC 1 □ M 2XXF 76 Director 578-46-2881 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or incompany or other trainments. 10b. County 10a. State Director 1 Yes 2 No WALDORF CHARLES MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. Funeral 20601 11850 OAK MANOR DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married by 1 Yes 2X No Specify: Specify: WHITE If Yes, Give 3 Widowed MXDivorced Completed Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) STONE COMPANY MACHINE OPERATOR 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) DOROTHY KATHERINE DREOS ည NATHANIEL NATHAN ROBERTS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DEL MAR ST., MELBOURNE, FL 32951 DOROTHY NEWTON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State **APR** 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State ALEXANDRIA, 14,2011 METRO.CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P. 5635 WASHINGTON AVE., LA PLATA, MD 20646 21. Signature of Funeral Service Licens M00641 TM 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death stone 4 Physician/ disease or condition resulting in death) Medical Due to (on as a consequence of) Examiner HO CAL MI Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examiner Drna Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of): resulting in death) Last as been signed by the attending physician 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Month Day in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No After this certificate has death? 2 🛮 No page 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be funeral director, examiner? Other: Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Man of Death Certificate: injury 1 / Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation Accident 2 Acciden 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f, Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examíner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3[29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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32. Registrar

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31. Date filed (Month, Day, Year)

Annopolis, MD 2140

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 29. 2011 Jeannette M.T. O'Connor 5:20pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Hill Haven Assisted Living Facilities Adelphi Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Days Hours Month, Day, Year) 25 **Director** 497-20-6089 85 Ohio Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Washington 1 X Yes 2 No DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4606 Kansas Avenue, NW 20011 u.s.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 \(\square\$ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced WWII White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. Is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cartographer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Henry Toublanc Eugenie Plantard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Page 1 and 2: James P. Crassas - Friend 1031 Cresthaven Drive., Silver Spring. MD 20903 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 04/05/2011 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Hypertension Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Pregnant at time of death Unknown signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Osteomylitis Completed 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypothyroid 24a. Was an has autopsv certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 🗓 No 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) this within 24 hours after oteau..

To the Funeral Director: After thi Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and on the property of the basis of examination and one in the state of the property of the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 30.

State Registrar Raman Tuli,

31. Date filed (Month, Day, Year)

10810 Darnestown Road, Suite 202, Gaithersburg, Maryland 20878

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

APR 04 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8:50 William H. O'Day SR. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** XX M 2 D F Months Hours Min Days 472874933 212-30-9757 Director MD Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 shruld be "lied within 72 hours after death with the Maryland ment of Health and Ments." Hygiene. 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 YesXXX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 306 Cedar Lane 21403 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married XX Married White 1 Yes XX No Specify: If Yes, Give Year or Dates. Korea Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter USNA Public Works Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Ferdinand O'Day SR. Edith May Ward 19a. Informant's Name/Relationship (Type, Print)
Sarah E. O'Day Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Annapolis, MD 21403 306 Cedar Lane Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 4/7/2011 Crownsville, MD 21. Signature of Funeral Service Picensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown 9 Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has blirector, page 2 s autopsy death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Phpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di Manner of Deeth 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred nth, Day, Year) 5 Pending work Accident 1 Tyes 2 🗆 No Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗋 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) M43 30. Name and add rson who completed cause of death (Item 23a) (Type, Print) 21061 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen O'Toole April Waneda Day 2011 2:42 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Allegany Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 💢 F Months 85 Director 06/11/1925 Maryland |218**-**16-2977 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 110 Pennsylvania Ave, Apt #1 21502 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Completed White Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Retail permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event; i Be 17. Father's Name (First, Middle, Last) Should be file and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Oretta Riggleman Melvin Edward Bowman Aleatha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Martin D. O'Toole, Jr. / Son 12206 Ash Fleetwood Drive, LaVale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Sunset Mem. Park 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State 04/08/2011 Cumberland, MD 4 Donation 5 Other (Specify) 21. Sin cur of Funeral S rv e Liven: 22. Name and Address of Facility Adams Family Funeral Tome, P.A. 404 Decatur Street, Cumberland, MD 21502 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death COYENA disease or condition resulting in death) O YNS Due to (or as a consequation of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav signed by the at d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à No 3 □ Probably 4 □ Unknown 1 Tes 24a. Was an

Physician Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending holysician and Division of Vital Records, P.O. Box 68760 page 2 should 4 hours after death. uneral Director: After this ed filled in by the funeral di

Completed To Be Certificate: Medical сотретер

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie

29c. License number

00033280

April 5, 2011

21502

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue, Cumberland, MD Sunil K. Gupta, M.D.,

APR 0 31. Date filed (Mo Year 6 82. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month March 27, 20 IT Olin Russell O'Haver 8:46 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Western Maryland Regional Medical Center Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Country) Maryland Months Days Hours Min. (Month, Day, Year) April 13, 1928 213-22-4376 Director Usual Residence of Decedent show 10b. County 10a State 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No Maryland Allegany Lonaconing 9 10e. Street and Number 10f. Zip Code must be 10g. Citizen of What Country? Funeral 23a 17720 Lower Georges Creek Road Lonaconing **USA** items death 12. Was Decedent Ever in U.S. Armed Forces?,
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner ö 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Coal 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ္ John Howard O'Haver Rosa Edna Broadwater other traumatic 19a. Informant's Name/Relationship (Type, Print) ege 1 and 2 si cepartment of Health an Important: If item 27 is n any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike O'Haver - Son 16110 Bucks Hill Road, Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date March 30, Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Laurel Hill Cemetery Moscow Mills, Maryland 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Anoxic encephalo disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner days Sequentially list conditions, if any leading to immediate Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Yeurs and resulting in death) Last Due to (or as a consequence of attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year the Unknown 9 Unknown signed by t if be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ obstructive Lung Completed 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page After this certificate I perform Yes 2 No 1 Yes 2 Ho 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 XYes ပ္ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? thin 24 hours after death.

The Funeral Director: All mipleted filled in by the fu Accident 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 721488

Registrar

10

andra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

(Month, Day, Year)

2011

MAR 29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year Рм Charles Robert Poe 45 Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | March 16, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 ፟፟ M 2 □ F Director 88 578-20-0483 Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director or 28a-f st notified 1 🗌 Yes 2 🖾 No Lexington Park Maryland St. Mary's 10e. Street and Number 10f. Zip Code þ 109. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 18758 Three Notch Road 20653 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 X Widowed 4 □ Divorced Specify: Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) 8 Self Employed Waterman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file and Mental I မ Albert Franklin Poe Eva Estelle Knott permit. Page 1 and 2 should bu Department of Health and Men Important: If item 27 is marke any injury or other traumatic onee. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Mae Poe Johnson / Daughter 42850 St. John's Road, Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place, April 16, 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, Maryland Charles Memorial Gardens 2011 Thre of Funeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ALZHEIME disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death sate has been signed by the spage 2 should be detached to 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, ARTERY DISEASE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? After this certificate 2 🗆 No Yes 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes Other: 2 110 မ 1 Inpatient 2 ER/Outpatient 3 DOA 41 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Accident Investigation the 24 hours after deat Funeral Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide City or Town, State Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certi 29d. Date signed (Month. Day, Year) D0067788 12.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EENA KODAL MD. 14090 H.G. Trueman Road Ste. 2300, Solomons, MD 20688

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death POTTS Physician/ DOUGLAS March 1047 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery Social Security Number 9. Birthplace (State or Foreign Country) Michigan If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8 Date of Birth **Funeral** 1 🛛 M 2 🗆 F (Month, Day, 08/20 548-52-8301 Director 82 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Department of Health and Mental Hygiene. Important: I stem 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at one. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1008 Venice Drive 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 1 No 195
If Yes, Give 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 No 1957-Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Caucasian 3 Widowed 4 Divorced 1959 Year or Dates 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Physician Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Enos Aitken Potts Rena Klooster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1008 Venice Drive. Silver Spring, Maryland 20904 Martha Sue Potts - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State George Washington Cem 04/01/2011 | Adelphi, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Pneumonia Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Disease artery 1 Yes 2 No 3 Probably 4 Unknown Progressive denuting Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ₺ No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 29c. License number D61007 MD March 26, 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland Kenneth Khandagle Silver Spring Dr #320 12520 Prosperity 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ March 30, Day 2011 Year Helen Marie Palermo 11:45 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICV SAINT VINCENT CARE CENTER EMMITSBURG 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 M 2 9 Months Days Hours Min 042-44.9481 PALEGUO Director 101 ITAL Usual Residence of Decedent 28a-f show 10a. State 10b. County ms 23a or 28a-f shormust be notified at 10c. City, Town or Location 10d. Inside City Limits Director Emnitsburg 1 X Yes 2 No Maryland Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21727 335 South Seton Avenue USA ral", or iten I Examiner n 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exa If Yes Give Completed white 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16b. Kind of Business Industry
Religious Community 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Daughters of Charity Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Concetta Italia Salvatore Palermo and 2 should b Health and Me tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Goldsborough, Servant 333 So. Seton Avenue, Emmitsburg, MD 21727 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Semeter OS Day) oSother place) 20c. Location - City or Town, State 1

■ Burial 2

□ Cremation 3

□ Removal from State 4/2/2011 Emmitsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Provincial House Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure, List only one cause Interval Between Onset and Death n each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 death? certificate 1 Yes 2 No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No 4 Nursing Home 5 Residence 6 Other (Specify) After this c 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident injury 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and til 0018705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Emmitshura 310 Siscton arrol 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 3

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 18:06 PM 2011 George R. Plummer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Western MD Regional Medical Center Cumberland If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) **December 06, 1937** 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 | F Min. Maryland Yrs Director 73 214-36-6349 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 X Yes 2 □ No Maryland Allegany Frostburg 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 154 Spring Street 23a Funeral U.S.A. **Examiner must** 21532-12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. 77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Tread Builder Kelly Springfield Tire Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George B. Plummer Edna M. Lancaster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Kevin Plummer 21774-5709 Meyer Avenue Maryland New Market 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State **Cumberland Crematory** April 01, 2011 Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility licholas Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ACUTE CEREBROVASCULAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to lor as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Day Year Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe page 2 1 ☐ Yes 2 ☐ No Yes 2 XIN 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes |요 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28c. Injury at work?
1 Yes Certificate: 28b. Time of 28d. Describe how injury occurred Natural Accident (Month, Day, Year) To the Hospital or within 24 hours after death.

To the Funeral Director: After the Funeral Director After the further or filled in by the further than 100 months of the further or within the furthe 5 Pending injury 2 🗆 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death as a stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Prantice: 7. The cost of my knowledge death occurred at the time date and place and due to the cause(s) and mentioner stated. (Check 29b. Signature and title of certifier 29c. License number HSidhu 5 MARCH 30, 2011 D26907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Med Harjit Sidhu 925 Bishop Walsh road Cumberland, MD 21502

DHMH 17 Rev 7/2009

State Registrar

Saltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patrick 2349 Dan Boyd March 28 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 76 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Month, Day, Year) 1935 1 🛛 M 2 🗆 F Months Days 230-38-0497 Director Virginia Jan. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC none Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3322 14th Street, N. W. 20010 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 1 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Shipping Clerk Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Queen Esther Vones should be file and Mental F is marked of Lynwood H. Patrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Patricia Oyewamide (Daughter 631 Newton Place, N.W. Washington, DC 20010 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Chesapeake Crematory 04/01/2011 Beltsville, Md. 4 Donation 5 Other (Specify) 22 Name and Address of Facility W. H. Bacon Funeral Home, 3447 14th Street, N.W. Was 21. Signature of Funeral Service Licens e Washington, D.C. 20010 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Lister Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? ō Month Year Pregnant at time of death ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Records, The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy 2**X** No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certifics completed filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a

State Registrar DMIT

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31. Date filed (Month, Day, Year,

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ March 37 201 Ta 11:30am Vivian Mandis Pappas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Friends Nursing Home Montgomery Sandy Spring If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 578-28-5304 84 washington. DC **Director** Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifitied at any injury or other traumatic event, the Medical Examiner must be notifitied as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Olney 1 Ves 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 u.s.A. 17702 Swan Theatre Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Florist Owner/Operator Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Harry John Mandis Demetra Christeas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17702 Swan Theatre Court, Olney, Maryland 20832 Stephanie Noland - Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Lincoln Cemetery 04/06/2011 Brentwood, Maryland . Ignature of Janes I Service I icensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MOOZO 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Ovarian Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, any, reaching to immediate cause. Enter Underlying Examine Due to (bras a consequence of): been signed by the attending physician and should be detached for use as the burial-tr nsit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed? Yes 2 X N 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner' Other: 1 Tes 2 🛛 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 X Natural 5 Pending Accident within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2
To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

APR 05 201

31. Date filed (Month, Day, Year)

-0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D18726

April 01, 2011

Please Type or Print in Black Indelible Ink. Frey Place Amend I tem 21 per new Place Indelible Ink. Frey Place Amend I tem 21 per new Place Indelible Ink. Frey Place I tem 21 per new State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ $2\check{O}^{r}1$ 7:50 P M Mary Lourean Porter Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Alleghany Golden Living Center Cumberland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 ⋤ F Months 9/18/1930 West Virginia 80 Director 171-30-2988 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Alleghany 1 X Yes 2 No Cumberland 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 512 Winfred Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2x No Specify: If Yes, Give Specify. Completed 3 😾 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Farming Farmwork Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alston Ira Spielman Mary Ann Shipaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14405 Ruth Lane S.E. Cumberland MD 21502 Timothy Porter/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Tabor Cemetery 4/6/2011 Berkeley Springs, WV Mt. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hunter-Anderson Funeral Home John Anderson per DVR 36 S Green Street, Berkeley Springs WV 25411 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) years Coronary Artery Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant the hed s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Melitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an is certificate has l director, page 2 s autopsy perform death? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural 5 Pending injury Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0054004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Shiv Khamma 1221 E national Highway LaVale MD 21502 31. Date filed (Month strar's Signature State APR"20 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2011 PAGE ROBERT LEE 4:43 Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Numbe 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Months Hours 1 XM 2 🗆 F Director 80 217-28-6649 Feb. Usual Residence of Decedent 28a-f show ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 ☐ Yes 2X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5618 Honeysuckle Court 21703 United States items 2 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, ed other than "natural", or itel event, the Medical Examiner Armed Forces?

1 X Yes 2 \(\subseteq \) No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates. Korea 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working within 72 permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Walter Page Mabel Estelle Carev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5618 Honevsuckle Court, Frederick, MD 21703 Octavia Mae Page / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 13. 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Olivet Cemetery 2011 Frederick, Maryland 21. Signature of Funeral Service Licer any in Keeney and Bastord PA Funeral Home, <u>106 East Church Street,</u> Frederick, MD 21701 23a. Part 1. Enter the disease shock, or heart failure g, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Susa Lardios disease or condition enic Medical resulting in death) Due to (or as a con etience of Examiner tien Sequentially list conditions, cause. Enter Underlying Exami disea Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury onas and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as s, outcome of pregnancy Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? has page 2 this certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No Other: 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After iniury 5 Pending Matural work? 2 \square No Accident Investigation the 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed (Check within 2 only one 29b. Signatu MDD 65378 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7th St Frederick mi

State Registrar 31. Date filed (Mont

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\underline{20}1^{\text{Year}}$ Physician/ April 3 2:00pm L. Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick 6202 A. Woodville Road Airy If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 ፟ M 2 ☐ F Months Nov. 5. 1923 California Director 536-14-8849 87 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 🏝 No Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6202 A. Woodville Road 21771 United States . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married \$ within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes Give 3 Widowed 4 Divorced Completed White Year or Dates. WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Johns Hopkins Applied and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Physics Laboratory Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mary Aleta Maguire Merle Alvin Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6202 A. Woodville Road, Mt. Airy, Maryland 21771 27 Mary A. Rogers/ Wife injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o nent of 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 22. Name and Address of Facility
Stauffer Funeral Homes
1621 Opossumtown Pike, 21. Signature of Funeral Service Lig Prederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cadse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner mesoath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE use 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Year Day Pregnant at time of death the P.O. been signed be should be det Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas page 2 s autopsy performed 1 Yes 2 No of Vital or Attending Physician: the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After (Month, Day, Year) Natural 5 Pending Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 2 🗌 No 1 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature a d title of certifie 29d. Date/signed (Month, Day, Year) 100 59924 2011 ess of person who completed cause of death (Item 23a) (Type, Print) 1502 S. Main St 2202. Mt Arry, MD MAKVIEW 2177 10 + 1 VA State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			State Registrar		Cer	tificate of L	Death		Reg. Ng? 1 2 7 3 6			
	Physicia	in/	Decedent's Name (First, Middle, Last)					Date of Dea Month	Day Year	3. Time of Death		
	Medic		Sandra Michelle					April	4, 2011 2:09 a. ^M			
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and the second			Hospice House of St 5. Social Security Number 6. Sex		- 4 h !-46 -1- 3	Callar If Under 1 Year		8. Date of Birt		Mary's		
	Funeral Director		218-92-6006	7. Age (In yrs. Ia	Yrs.	Months Days	Hours Min	. (Month, Day	y, Year) 9. B	irthplace (State or Foreign ountry) New York		
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	and shov	ğ	10a. State 10b. County		, Town or Loc					10d. Inside City Limits		
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	a or 2		10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?		
	is 23;	Funeral Director	45344 Deer Pond Lane			20	619		United St	ates		
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Maryland	should and N is ma		19a. Informant's Name/Relationship (Type, Pri	int)	19b. Mailin	g Address (Street	and Number or R	ural Route Number	r, City or Town, State, 2	Zip Code)		
Σ	nd 2 sealth nn 27 ner tra		Danny Rose/Husband		45344	Deer Po	nd Lane.	Califor	nia. MD 20	619		
ore	e 1 ar of 诀 if iter		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Remo			sition (Name of natory or other plac	ce)	Date	20c. Location - City of	or Town, State		
Ĕ	Page ment ant: l		4 Donation 5 Other (Specify)			emorial		Apzil18	Leonardto	wn, MD		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any righty or other traumatic event, the Medical Examiner must be notified at once.		21. Signatury of Funeral Service.Licensee	TH 150017	22 B	Name and Addre	s of Facility	Funeral	Home, P.A	i1, MD 20622		
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			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause	ns that caused the death se oh line.	n. Do not e	r the mode of dyin	g, such as cardia	c or respiratory arr	rest,	Approximate Interval Between		
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<u>_</u>	ding Physician; The le h. After this certificate ha funeral director, page	요	1 Yes 2 No	1 Inpatient 2 I	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injur	4 🗌 Nursing		lence 6 X Other (Spe ow injury occurred	ecify) House		
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Sio	Atten r dea ctor:	Certificate:	3 Suicide 6 Could not be	e. Place of Injury - At hor				28f. Location (S	Street and Number or F	ural Route Number,		
Division of Vital Records, P.O. Box 687	al or a safte		4 E Homicide determined	building, etc. (Specify)				City or Tow	n, State)	1		
	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: 2 Medical Examiner: Or	To the best of my knowle	edge, death o	ccured at the time	, date and place,	and due to the car	use(s) and manner as s	stated.		
	the H hin 24 the Fi	Me	only one) 3 - Certifying Nurse Prac	ctioner. To the best of my	knowledge, c	eath occurred at th	e time, date and p	lace, and due to the	e cause(s) and manner a	as stated.		
	5 7 8 19		29b. Signature and title of certifier	11		29c. License			29d. Date signed (Mor			
			110	00			0551	١١	4-5-	11		
			30. Name and address of person who complet Jennifer Schmidt				a Taon	ardtown	MD 20650			
	Stat	e	31. Date filed (Month, Day, Year)	37. Registrar's Signatu	ure		u., 11011	GI GLOWII,	11D 20050			
	Registra		APR 1 1 2011	Carma &	. 60	Kel						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 9:00 pm Ruth Franziska Rauch 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Ye July 12, 9. Birthplace (State or Foreign Country) Germany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🎾 F Days 78 Yrs. 124-24-5810 **Director** Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville Maryland 1 🗆 Yes 2 🏿 No Montgomeru 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20852 1801 East Jefferson Street 12. Was Decedent Ever in U.S. Armed Forces?
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1 Yes 2 X No signed by the atte Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Bleeding Duodenal Ulcer 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 No 1 Yes 25. Was case referred to medica ā Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 🗌 Yes Certificate; To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending work? 1 🗌 Yes 1 X Natural 5 Pending 2 🗌 No within 24 hours after death

To the Funeral Director: A

completed filled in by the fi 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Garrifying Nurse Fractioner: To the best of my knowle 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D07147 March 29. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Ave., Suite 700, Chevy Chase, Maryland 20815 Allen A. Nimetz, M.D.

DHMH 17 Rev 7/2009

State

Registrar

Day, Year

APR 04 2011

Baltimore, Maryland 21215-0036

Physic Med Exam

Division of Vital Records, P.O. Box 68760

	1 - State Registra
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Please Type or	Print in Black Indelible Ink. Ensur	e All Copies Are Legible.										
State of Maryland / Department of Health and Mental Hygiene												
Certificate of Death Reg. No.												
Middle, Last)		2. Date of Death										

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Physician/ Medical		Decedent's Name (First, Middle, Last) Jeanette Villa				Robey			2. Date of Death Month 2. Date of Death Month 3. Time-of Death Month 3. Time-of Death Month					
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should be filed within 72 hours after death with the Maryland and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f sho ris marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) iam J. Ro	bey, Sr.				18. Mother's Nam Shirle	ne (First, Middle, M y Frances		,	lacker		
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of Health of titem 27 ir other tra		20a. Method of Disp		Removal from State	20b. Pla	ace of Dispos	sition (Name of natory or other place	cel	Date	20c. Location	•	own, State		
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To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for	Medical	(Check 2	Medical Exami	sician: To the best of ner: On the basis of e se Practioner: To the	xamination a	and/or investi	igation, in my opinic	on, death occurred a	it the time, date an	d place, and d	lue to the ca	use(s) and manner state	ed.	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 04/03/2011 Physician/ Shirley Jean Rynarzewski \mathbf{p}^{M} 8:52 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1341 Matthew Drive Huntingtown Calvert Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 👿 F 225-46-3478 72 **Director** VA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director FI. Brevard Melbourne Beach 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? Funeral 351 Nikomas Way 32951 U.S.A. 11, Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ρ 1 Never Married 2 X Married 1 Yes 2 Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 K No Specify: "natural", 3 Widowed 4 Divorced Completed Specify: White Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hyglene. Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Automobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be Charles E. Hughes Dorothy Testerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Dillon/Son 1341 Matthew Drive, Huntingtown, MD 20639 item 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it 6 1 XBurial 2 Cremation 3 Removal from State Southern Mem Gdns 04/07/2011 Dunkirk, MD any injury 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lisa M. Mounts 8200 Jennifer Lane, Owings, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician Breast disease or condition vears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease of linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ 23d. Date of delivery in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated by page 2 should by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Yes 2 No 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 🔀 No ျှ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 XOther (Spenty)'s Residence After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident neral Director: A Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined e Funeral Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier DO059061 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arati Patel, MD 110 Hospital Road, Suite 212, Prince Frederick, MD 20678

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Trilby ROSSKOPF Physician/ April 3, 9:40 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Potomac Montgomery Potomac 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔏 F Hours Months Feb. 5. 1925 MaryTand Director 219-14-0099 86 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No <u>Maryland</u> Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10714 Potomac Tennis Lane 20854 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No
If Yes, Give Black, White, etc. ۵ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 🏋 Divorced Completed white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Office Assistant U.S. Government or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Philip Dachslager Ida Roypen I and 2 should be I Health and Me Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 916 Maryland Ave., N.E., Washington, DC 20002 Marvin Rosskopf, Son Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If ite any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) matory or other place United Hebrew Cemetery 04/06/11 Baltimore, MD 21. Signature of America Sehina Licentee Torchinsky Hebrew Funeral Home 254 Carroll St. NW. Washington. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Sudden Death Immediate Cause (Final Physician/ Arrythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). sician and burial-transit <u> Atherosclerosis</u> resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Physician: The law requires that the death certificate be Hypertension Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown ed by the a 9 Unknown P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Myasthenia Gravis 1 Yes 2 No 3 Probably 4 Munknown Respiratory Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy Gait Disorder Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 XNatural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 4, 2011 0 31319 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loreto Albiol, M.D., 8218 Wisconsin Ave., #305, Bethesda, MD

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

APR 0 5 2011

barker

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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partmit. I		21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.														
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 2011 Physician/ Donald Stull R. Jr. March 30 12:34 p.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Kline Hospice House Mt. Airy If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1XXM 2 | F Hours March Day 13ar 49 Maryland Director 219-76-1105 1962 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hydiene. Examiner must be notified at 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 10197 Crestview Drive 21702 USA items . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc "natural", or þ 1 Never Married 2 X Married 2X No Baltimore, Maryland 21215-0036 Yes white 1 Yes 2 No Specify: 3 🗆 Widowed 4 🗆 Divorced If Yes, Give Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) General Manager Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ರ Donald R. Stull, Sr. Jeany L. Cooke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Renee Stull - wife 10197 Crestview Drive, Frederick, Maryland 21702 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 x Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Resthaven Memorial 4-3-2011 Frederick, Maryland Ponation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home any 1621 Opossumtown Pike, Frederick, Maryland 2170 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each liqu. Interval Between Onset and Death Immediate Cause (Final Pnysician 0 disease or condition nouvMedical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 2 No 2 should be detached 9 Unknown 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page performed? Yes 2 No this certificate 1 Yes 2 🔲 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 1🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signat ess of person who completed cause of death (Item 23a) (Type, Print) 21702 , A.Z. HEGA Frederich MO

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $20\overset{\text{Yea}}{1}$ 11:49 a M April Shanahan Patricia Lee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 39218 Yates Road Clements If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 M 2 X F 06/23/1960 California Director 50 214-82-3545 Usual Residence of Decedent or 28a-f show notified at 10b. County should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

I show the state of the s 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Ves 2 K No St. Mary's Maryland Clements 10q. Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral 39218 Yates Road 20624 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Dog Groomer permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>tr</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Franklin Domonousky Sandra Clary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39218 Yates Road, Clements, MD 20624 Sandra Bean/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) 04/09/2011 Charlotte Hall, MD Brinsfield-Echols 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, Eden MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 mos Immediate Cause (Final Phylician CAD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Diabetes vrs Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innertal director, page 2 should be detached for use as the burial-transit Chronic Renal Insufficiency yrs. that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 2 yrs. Hypertension Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached g 🗌 Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No မ 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 A Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 335 6

State Registrar ma

20650

LEONARDTOWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Rec

40900 Mucherts LANE

31. Date filed (Month, Da

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20°11 2:45 PM April Marion Dunbar Sterling Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 21745 Newtowne Neck Road Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, March 20 1 □ M 2 🔀 F Hours Year. Country) 93 Yrs. Director Maryland 212-14-7170 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 🔀 No St. Mary's Leonardtown Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21745 Newtowne Neck Road 20650 USA "natural", or items edical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant. If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Lucy May Beal Paul Waldron Dunbar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21745 Newtowne Neck Road, Leonardtown, MD 20650 <u> Christine S. Senese / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 13 ment of 🗵 Burial 2 🗆 Cremation 3 🗀 Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 2011 Aloysius Cemetery Leonardtown, Maryland 22. Name and Address of FacilityMattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 Si mature of Funeral Service Licens gray Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to or as a con quence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death ed by the a detached t signed b Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certificate has been significant of the funeral director, page 2 should to completed filled in by the funeral director, page 2 should to Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Na Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basic of examination and a limitation of the cause (s) and manner as stated. Medical 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Name and address

31. Date filed (Month, Day, Year)

APR 11

nnifer M. Schmidt, D.O.

40900 Merchants Lane, Suite 205, Leonardtown, MD 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 37. 2011 a 1:45 pm ilezingen MOILIAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Potomac Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 1 7 2 2 7 7 9 2 5 218-27-0867 85 U.S.S.R. Director Usual Residence of Decedent 28a-f shov e filed within 72 hours after death with the Maryland that Hyglene. et orlver than "natural", or items 23a or 28a-f shon event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director 1 Yes 2 X No Rockville Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 u.s.A 24 Sterling Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify. Completed 3 X Widowed 4 Divorced White. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Psychiatry Psychiatrist Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Lev Broderzon Sophia Broderzon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Sterling Court. Rockville, Maryland 20850 Eleonora Slezinger - Daughter Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place, ☐ Bornal 2 🗵 Cremation 3 ☐ Removal from State Ft. Lincoln Crematory, 04/05/2011 Donation 5 Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Fun al Servic License Sanature M0070 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the offease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastati Physician/ breast disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last the a tending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death sate has been signed by the a tendir page 2 should be detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an autopsy certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 2 Accident
3 Suicide within 24 hours after death.

To the Funeral Director: Aft completed filled in by the ful 24 hours after death. Funeral Director: Al 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D50534 3/31/201/ nomas Masteria 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS MASTERSON MD 6858 OK Dominion Dr #104 M CLEAN VA 2210 |

Registrar

State

0 4 2011

31. Date filed (Month, Day, Year)

Bis Colinson.

82. Registrar's Signature

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Physicia		Registrar 1. Decedent's Name (First, Midd	fle,Last)		rincate o			2. Date of De	Reg. No. ath		3. Time of Death	
Medical Exami		Kyree Efrem Si	Lmms					Month March 24		ear	0439 hrs	
		4a. Facility Name (if not institution 2951 Victory Lane	on, give street and r	number)		4b. City, Town, or Suitland	Location of Dea	ath	4c. County Prince	of Death George's	5	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea		Irs. 8. Date of B	irth (MM/DD/YYY	(Y) 9. Birth	place (State or District of	
Director		578-23-7954 Usual Residence of Decedent	1 X M 2 F	18	Yr	Months Day	s Hours M		27, 199	2 Cour	^{ntry)} Columbia	
any	H	10a. State 10b. County		10c. City	, Town or Loca	tion					10d. Inside City Limits	
Maryland 28e-f show	ō	D.C.		Was	hington						1 X Yes 2 No	
Mary rr 28a-	Director	10e. Street and Number 2667				10f. Zip Code			10g. Citizen of V		•	
vith the	alD	Martin Luther 11. Marital Status	King, Jr.	Ave.,S.	E .	20020 as Decedent of His	spanic Origin? (Specify Yes or N	United		an Indian, Black,	
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21215-0036 buld be filed within 7 Mental Hygiene. marked other than it event, the Medica	Completed	12			Stu	dent	_		Educa			
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212 ould be Mentz mark	To Be	Efrem Zimbalis 19a. Informant's Name/Relations			19b. Mailin	g Address (Stree	Kec1a et and Number o	Kioni Si r Rural Route Nu	Lmms Imber, City or To	ity or Town, State, Zip Code)		
MD d 2 sho lith and n 27 is		Kecia Simms/Mo	ther		Washi	ngton,Di	strict	of Colum	<u>ıbia 200</u>	20		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-7 sho injury or other traumatte event, the Medical Examiner must be notified at once.		20a Method of Disposition 1 X Burial 2 Cremetion	n 3 Removal	from State Na	Place of Dispos	sition (Name of ce her place) Harmony Park		Date	20c. Location			
Baltimore, permit. Pages 1 an Department of Hes (important: fite injury or other tr	-	Donation 5 Other S		Mei	morial	Park	04	/04/2011	Landov	er,Ma	ryland	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burfal - transit	Physician/Medical	UNPENDED	d AMENDED)								
Box 68760, e death certificate by the attending physical for use as the but	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the										
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ras after death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach.	d b				-			_ 1 _ Y	es 2 🗸 No	3 Proba	ably 4 Unknown	
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of Vital Recoing Physician: The law After this certificate has uneral director, page 2 s.	Completed							perf 1 ✓ Yes	ormed? 2 No	death? 1 ✓ Yes	2 No	
1 of Vital Recing Physician: The L	B	25. Was case referred to medica examiner?	Hospital:	Inpatient 2	ER/Outpatien		of Death (Chec	ck only one) sing Home 5] Bosidoneo &	Othor:	Saana	
of V	밁	1 Yes 2 No 27. Manner of Death	28a. Dat	te of Injury	28b. Time of		iry at Work?	28d. Describe	how injury occu		306116	
Sion ttendii death. rtor: /	atio		ding estigation FOUN Mar 24	th, Day,Year) D: I, 2011	FOUND: 0427 hrs	1	Yes 2 ✓ No	Subject sh	ot			
Divisior pital or Attend ours after death feral Director: filled in by the	Certification:	dete	lid not be	ace of Injury - At h Parking Lo		et, factory, office I	building, etc.	or Town,			al Route Number, City	
To the Hospital within 24 hours To the Funeral Completely filled		29a Certifier	hysician: To the be			rred at the time, d	ate and place, a	1			d.	
To the Hos within 24 h To the Fur	Medical	- 4	aminer:On the basis and manner		and/or investiga			d at the time, dat				
展	2	29b. Signature and title of certific	er (/	1		29c. Licens O.C.			29d. Date sig March 24		th, Day, Year)	
3	}	30. Name and address of person	n who completed ca	use of death (Iten	n 23a)				1			
		Zabiullah Ali, M.D.	Assistant Med	ical Examine	111 Per	n Street, Bal	timore, MD 2	21201				
Sta Regist	ate rar	31. Date filed (Month, Day Year)	2011	Registrar's Signat	. pa	Kil.						
DHMH 17 Rev 1/20 OCME 2006	001			ana,	ORIGINA	ıL					OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 31. 6:00 am C. Francis Anthony Silva Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson 5. Social Security Numbe . Age (In yrs. last birthday, 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 **X** M 2 □ F Months March 03 043-22-7590 Director 84 Connecticut Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral 8813 Shining Ocean Way 21045 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No Army Black, White, etc. 1 Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 345 1 ☐ Yes 2 X No Specify: If Yes, Give Specific frican-American 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 72 life. DO NOT use retired) permit. Page 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Government Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Cartano L. Silva Antonia Almirda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8813 Shining Ocean Way, Columbia, Maryland 21045 Renee M. Silva - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 04/07/2011 Silver Spring, Maryland 4 Donation 5 Other (Specify) Gate of Heaven Cem. 21. Signature of Fun and Service licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. N100709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Jeev 5 Medical le to (or as a consequence Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) ending physician a use as the burial-Physician/Medical Box 68760 signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should matoro 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has performed Yes 2 death? certificate 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 🔁 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 2 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 Tyes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d title of certifier 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Changey ST M MANUEL 6701 31. Date filed (Month, Day, Year) State 0 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 3,12,per phy, g918, 8-19-11 sm Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Michael B. Sassani 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth Jan 19, 1946 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1 ☑ M 2 ☐ F Hours **Director** 219-48-9380 65 Usual Residence of Decedent or 28a-f show Director and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7907 Takoma Avenue 20910 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 Way Yes 2 No
If Yes, Give
Year or Dates 1971-75 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Federal Government Media Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael J. Sassani Alice Gieselman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Koby/Wife 7907 Takoma Avenue, Silver Spring, MD 20910 tem 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 permit. Page 1
Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Gate of Heaven Cemetery ${\stackrel{ ext{cermetery, crematory or other place)}}{100}} {\stackrel{ ext{def}}{100}} {\stackrel{ ext$ Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 500 University Blvd. .W, Silver Spring Part 1. Inter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Cancer Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tra-Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes ≥ ∟ 9 ☐ Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Thinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) exteminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗌 No ရ 1 Inpatient 2 ER/Outpatient 3 I DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accider
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 [29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 52326 3/3/ 6+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James K. Lightfoot, MD 7600 Carroll Avenue, Takoma Park, MD 20912 31. Date filed (Month, Day, Year) APR 0 4 2011 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SCHWART 10.58 F 20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death were a 1-10 ward Ounk 205 olumbis 0 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** If Under 8. Date of Birth 9. Birthplace (State or Foreign Months 1 □ M 🔀 🖾 F 1 1 2 7 Pro 12 Country) MD 97 Director 224-60-3391 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director VA Arlington Arlington 1 Yes XX No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 22207 4215 Vacation Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married should be filed within 72 hours after on and Mental Hygiene. 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Dept of Treasury Director Foreign Assets permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname)
Adele Kempner 17. Father's Name (First, Middle, Last) ၉ Samuel Wolman 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Schwartz Axelrod 10001 Windstream DR. Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date **Burial 2 Cremation 3 Removal from State Hillcrest Memorial 4/5/2011 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 9. 70 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause, Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examir requires that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law hin 24 hours after death. the Funeral Director: After this certificate has autopsy performed' 1 Tes 2 No Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2. No ည ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 2 aumil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIVER MECK Road State 5 201

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** STUART PM LOUISE March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AlleGANY Center The Lions Cumberland If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🗷 F Hours 212-24-0313 Director 11-4-1926 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examinar must be notified at Director CUMBERLAND 1 ☐ Yes 2 ☐ No MD ALLEGAN 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a or DRIVE 21502 901 SETUN USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any Injury or other traumatic event Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Whit 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DEPARTMENT STORE Associate BUYER ICLERK 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELIZABETH LEROY WILLISON ADA ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HYNDMAN PA 15545 FREDRIE 265 Churchst. WILLISON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ■ Burial 2 □ Cremation 3 ■ Removal from State HUNDMAN HYNDMAN CEMETERY 3-30-11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 169 Clarence 5+ Hynchun PA 21. Signature of Funeral Service Licenses Momm HARVEY H. ZEIGLER FUNERAL HOME INC 15545 23a. Part 1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 5/2150 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy perform 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1☐ Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 No hours after death. within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number D0055325

State Registrar 31. Date filed (Month, Day, MAR 3 1

925 Bishop Walsh Road, Cumberburd, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #27, nls, State of Maryland / Department of Health and Mental Hygiene per phy., 03/28/11, Allegany Co.1 - State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FLORA JONES SHIPMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Allegany Cumberland 9. Birthplace (State or Foreign Country) West Virginia Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 6. Sex **Funeral** (Month, Day, Year) 07/18/1915 1 - M 2 - XI Director 220-10-7775 95 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 1 Tes 2 No WV Mineral Keyser 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. Route 5, Box 387 26726 "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates and Mental Hygiene.

is marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the onee. Retail Store Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Elizabeth Wright Newton Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Route 5, Box 388, Keyser, WV Norma Alt / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State 4 Donation 5 Other (Specify) Bapt.Ch.Cem. 103/27/2011 Fort Ashby, WV 22. Name and Address of Facility Upchurch Funeral Home 21. Signature of Funeral Service Licens P.O. Box 1260, Fort Ashby, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death sbeen signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ You 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? this certificate 1 Yes 2 No Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 🗌 No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Pl.v.e o V jury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Numb determined HEART LA NO LURSING HOME Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only of 29d. Date signed (Month, Day, Year) DO01821 6 address of person who completed cause of death (Item 23a) (Type, Print) MD 21502 2501 MD 31. Date filed (Month, Day, Year) State MAR 28 2011 arke Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		Registrar 1. Decedent's Name	e (First, Middle	e, Last)		Ce	runcau	e Oi L	Jeaur		2. Date of De	Reg. N	6. 01	***	3. Time of Death
Physicia Medio		Albert	Doug1a	as Sharp,	III						April	3, ^D	ay 201 1	ear	5:15 a ^M
Examin		,		, give street and number	er)	4b. City, Town, or Location of Death							Death		
		20 Coath 5. Social Security No			A ma //a uma /	a at hirth day)	01a	ney	If Under	24 Ure	O Data of Di		Montgo		
Funeral Director		213-66-23		6. Sex 1 ★ M 2 □ F				Days	Min.	8. Date of Bi	y, Year)	953	9. Birthplace (State or Foreign Country) D • C •		
d tt	_	Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town or Location								1	0d. Inside City Limits	
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the M or 28	Ξ	10e. Street and Nun					10f. Zij	o Code				10g. C	Citizen of Wha		itry?
n with	Funeral	20 Coat	tbridge	Court		20832								SA	
pereft. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☒ Never Marri 3 ☐ Widowed		If You Give	s? & No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bla						14. Race - Black, Specify:	Americ White, 6 Whi	etc.	
2 hour	plete	(Spe		nt's Education est grade completed)			dent's Usu			st of work	ina	16b.	L Kind of Busir	ness Ind	dustry
ithin 7; ene. r than the Me	Completed	Elementary/Seco	, , ,	College (1-4	or 5+)	life. E	(Give kind of work done during most of working life. DO NOT use retired) Conductor						mtrak		
the filed whental Hyginked other it event, it	To Be	17. Father's Name (I	First, Middle, I	Last) S Sharp, Jr	•						e (First, Middle Joan				
nd 2 should ealth and N n 27 is ma ier trauma		19a. Informant's Name/Relationship (Type, Print) Susan M. Ruth/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 745 West Princess Street, York, PA 17401													
Page 1 arment of Herant: If item		20a. Method of Disp 1 X Burial 2 4 Donation	☐ Cremation	3 ☐ Removal from St Specify)	ate C	Place of Disperentery, cre klawn	matory or o	other plac		A	pri1 6 2011		ckvi1		
peratt Depart Impor any in		21. Signature of Fu	neral Service	censee		F ²	Panci 00 Un	g Addres	ssete sity	Mns Blvd	Funera	l Ho Silv	me Ind	ing	, MD 20901
		23a. Part 1. Enter t	the disease, or	complications that cau	sed the deat										Approximate Interval Between
Physician/ Medical		Immediate Cause (disease or condition resulting in death)	(Final	_ a Liver	Failur										Onset and Death
Examiner		i			as a conseq	uence of):									
ted	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate rlying iinjury	b. Due to (or	uence of):							-			
cate be executed physician and s the burial-transit		that initiated events resulting in death) I		Due to (or	uence of):):									
ificate be ig physici as the bu	Medi	IF FEMALE:													
requires that the death certificate be been signed by the attending physic should be detached for use as the bu	Physician/Medical	23b. Was decedent in the past 12 in Yes 2 G	months?	23c. If yes, outco 1 Live Bir 4 Pregna 9 Unknov	th 2 🗀 Fetant at time of	al death 3	Ectopic Other (s		СУ				23d. Date of Month		ery Day Year
ires that the signed by t d be detach	by P			ons contributing to dea		sulting in the	underlying	cause giv	ven in Part	t 1.	23e. Did	tobacco	use contribu	ute to th	ne cause of death?
v requires been sig should b	ted										1 🗆	Yes 2	2 □ No 3 ²	☑ Prol	bably 4 🗆 Unknown
The law re cate has bo page 2 sh	Completed										24a. Was auto perf 1 \square Yes	opsy ormed?	prid dea	or to co	psy findings available mpletion of cause of
ding Physician: h. After this certific funeral director,	Be	25. Was case referre	ed to medical No	Hospital:				Oth			k only one)				
Physer this eral dil	6; 10	27. Manner of Deat		28a. Date of	injury	ER/Outpatie		OA Pari	4 ⊔ N		ome 5 Res 28d. Describe			Specify	<u>}</u>
ading sath. rr: Afte re fun	ficat	1 🖺 Natural 2 🔲 Accident		igation	Day, Year)	injury	М	work	₹? Yes 2 [□No					
To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s	al Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could detern	28e. Place of	Injury - At ho , etc. <i>(Specif</i>)	ome, farm, st	reet, factor	y, office			28f. Location (City or To			or Rural	Route Number,
Hospi 24 hou Funer eted fill	Medical	(Check 2	Medical I	Physician: To the bes Examiner: On the basis	of examinatio	n and/or inves	stigation, in	my opinio	on, death c	occurred a	t the time, date	and plac	e, and due to	the car	use(s) and manner stated
To the within To the comple	Σ	only one) 3 29b. Signature and		y Nurse Practioner: To	the best of m	y knowledge,			e time, dat e number	e and plac	be, and due to t	-	ate signed (A		
10		P. L	EDA	tus m	\sim		1	77	79	34		AC	RIL	4	12011
		30. Name and addre	ess of person	who completed cause	of death (Item	23a) (Type,	Print)	HL	PL	- B	AUTI	Ma	SRE	M	24207
Stat Registra		31. Date filed (Mont	PR 05	2011 32 Aeg	istrar's Signa	ture &	ares				•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieng 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Wilmer Lenwood April Seek 2011 10:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4312 Holly Ridge Road Rockville Montgomery 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Young 25, Birthplace (State or Foreign Country) **Funeral** Days Min 1 XM 2 F Director 216-12-4195 88 Yrs 922 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 Yes 2 XNo Rockville 10e. Street and Numbe 10g. Citizen of What Country? 4312 Holly Ridge Road 20853 ed other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married X Yes 2 No Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify Specify: White 3X Widowed 4 □ Divorced Year or Dates. 1942-43 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. U.S. Dept. of Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien? is marked other the Justice <u>Carpenter</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Earl Seek permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Harriett Catherine Leizear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Agnes Graziano/Daughter Carrera Court, Inwood, WV 25428 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Heaven Cemetery 4/8/11 Gate of 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Signature of Funeral Service F? Name is Agrees of Thins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or orn lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Debility disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examiner Due to (or as a consequence of). attending physician and I for use as the burial-try sit that the death certificate be executed Cerebrovascular Disease that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Hypertension 4 🖺 Unknown Records, 1 Yes 2 No 3 Probably Completed has been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy autopsy performed? page certificate 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 🖾 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA After this o 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M within 24 hours after death

To the Funeral Director: /
completed filled in by the i Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63232 April 4, 2011 M.D. 30. Name and address of pe rson who completed cause of death (Item 23a) (Type, Print) Tao Yu, MD P.o Box 10067, Gaithersburg, MD 20898 31. Date filed (Month, Day, Year) APR 05 2011

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State of Maryland / Department of Health and Mental Hygien 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2011 Year **Physician** APRIT. a^{M} 7:05 WILLIAM RICHARD SMITH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 10672 Worton Rd. Worton 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours t**y**⊑ M 2□ F 87 June 1, Maryland Director 218-12-1295 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 Yes 2 □ No Director MD Kent Worton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 10672 Worton Rd. 21678 Funeral 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status filed within 72 hours after 1 ∐Yes 2½ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2 📉 No White Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Important: If Item 27 is marked other the any injury or other traumatic event, It I once. Grounds Maintenance Chemical Company 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Dewberry Irving Smith ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Smith (wife) P.O. Box 3 Worton, MD. 21678 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Chester Cemetery 4/14/11 Chestertown, MD. 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus () al disease or condi-resulting in death) **Physician** arkenson /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed Due to (or as a consequence of) burialphysician Box 68760 Physician/Medical the attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 □ No P.0. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐Yes 2 ☐ No certificate existeral 1 ☐ Yes 2 🖼 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1.1 / Mun, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 415 Washington Ave. Chestertown, MD, 21620 Kin Kue Wun, M.D.

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Corerado

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No._ Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 5.40AM **Physician** orres 2011 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 221-72-5582 1**X**M 2□F Months Days **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or 28a-f show notified at 10a. State 10h Count 1 Yes 2 □ No ilminator Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ŏ ms 23a or must be n Mexico death 1 ral", or items 2 | Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 □ No Specify: þ exicar White 3 Widowed 4 Divorced "natural" Completed th and Mental Hygiene.
It is marked other than "naturitraumatic event, the Medical I 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Give kind of work done during life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) aborer 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Flores Andrade lorres ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Carmen Flores Health a 107 Simca Lane Department of Health Important: If item 27 any injury or other trong. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 21/2011 Yuriria GTO, Mexico 1 Burial 2 Cremation 3 Removal from State Cemeterio Municipal 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Family Funeral Home Strano + Feeley Family Funeral Home 635 Churchmans Road Nowlart NE 21. Signature of Funeral Service Rice Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the 88 IF FEMALE. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Dav Pregnant at time of death 5 Other (specify) 2 □ No signed by the at d be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 No 2 ER/Outpatient 3 🗌 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 🗌 Yes 2 Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the f 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month,

DHMH 17 Rev 1/2001

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32. Registrar's

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Trimble Eleanor Delores Physician/ Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cumberland Western MD Regional Medical Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 11/17/1929 Mary I and 81 215-26-7017 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State Director Cumberland MD Allegany 1 X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be r 21502 USA Funeral 806 Maryland Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Black 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene.
7 is marked other than "r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Retail Bookkeeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hilda Stephens ပ Winfield John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Russell L. Trimble, Sr. / Husband 806 Maryland Avenue, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Mem. Park 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Cumberland, MD injury or 104/02/2011 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21502 404 Decatur Street, Cumberland, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset an Death Immediate Cause (Final Physician/ 44 Cere brower disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list on allient if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death ed by the a Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ا 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an vivere autopsy findings available prior to completion of cause of death? has autopsy performed 1 Yes 2 No burs after death.

eral Director: After this certificate I filled in by the funeral director, page 2 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medital Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

29b. Signature and title of certifier

Vik Poonai, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

21502

Cumberland, MD

29,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 2011 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner Anne Arundel Harwood Chesapeake Hospice House If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 🗆 M 2 🗷 F Hours 09/08/1961 Maryland 49 Director <u>219-82-5162</u> Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 👿 No Maryland Anne Arundel Lothian 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number Funeral United States 5820 Brooks Woods Road 20711 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Enginering Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H Department of Health and Object of the Department of Health and Menta Important if item 27 is marked any injury or other trauments once. ည Patricia Ann Conrad Robert McMahon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5820 Brooks Woods Road, Lothian, Maryland 20711 Jack Twohig / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 04/04/2011 |Charlotte Hall, MD. 22. Name and Address of Facility Rausch Funeral Home, PA
4405 Broomes Island Road, Port Republic, MD 20676 21. Signature of Funeral Service Licensee M01206 Kyle S. Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Mas and Asath Immediate Cause (Final BREAS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-t Physician/Medical Box 68760 ed by the attending properties as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 AV6 Unknown 9 Unknown P.O. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2-No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has ral director, page 2 autopsy death? 1 ☐ Yes 2 ☐ No 1 Yes 2. No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 Other Specific VONIN Hospital Other: 2 146 ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA in 24 hours after death.

he Funeral Director: After this on the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 🗌 Yes 1 Natural 5 Pending 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifie 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) Name and address of person who completed o ause of death (Item 23a) (Type, Print) ENM 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03/11/2011 Daniel Aaron Thomas, Jr. 9:59 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert 8. Date of Birth (Month, Day, Year) 03/11/2011 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 60 60 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No Calvert Chesapeake Beach MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 8811 St. Andrews Drive U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry ntal Hygiene. ed other than " event, the Mer life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic even once. 18. Mother's Name (First, Middle, Maiden Surname) Daniel Aaron Thomas, Sr. Kristy Noel Rum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristy Rum/Mother 8811 St. Andrews Drive, Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State Lee Crematory 03/15/2011 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, 8125 Southern Md Blvd., Owings, MD 20736 21. Signature of Fureral Service Licensee Lisa M. Mounts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Prematurity Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed 2 \square No certificate Yes 2X No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 **X**No 1 Yes 10 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 5 Pending 1XXNatural 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Hospita 31. Date filed (Month, Day, Year) 32. Registrans Signature State

Registrar
DHMH 17 Rev 7/2009

MAR 1

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De			ental Hyg	iene 0	11 12760		
		1 - State Registrar AMEND \$9perFH, 4/8/11; BWW, McCo Certificate of Death					Reg. No. 2. Date of Death 3. Time of Death			
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Paul Taylor			Month	29 20	Year 9:44 A M		
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Local		March	4c. County			
	Examin	er	Washington Adventist Hospita					gomery		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		Inder 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)		
	Director		179-40-8085 1 1 M 2 □ F 61 Yrs.	World S Days 1100	IVIIII.	(Month, Day, 12/6/1	949	VA West Virginia		
	ld now at	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits		
	arylan a-f st fied a	Director	MD Prince Georges Hyatts					1X Yes 2 □ No		
	he Ma or 28 noti	Pir.	10e. Street and Number	10f. Zip Code		1	0g. Citizen of	What Country?		
	with t	eral	4922 LaSalle Rd.	20782			USA			
	tems er mi	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanie If Yes, specify Cuban, Me				ce - American Indian,		
9	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show tie event, the Medical Examiner must be notified at	by	1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give	1 ☐ Yes 2√☐ No Spe		,	Specify	ck, White, etc.		
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2	72 ho n "na Aedio	dr.	(Specify only highest grade completed) (Gi	ve kind of work done during DO NOT use retired)	edent's Usual Occupation kind of work done during most of working NOT use retired) Practice Specialis			e Georges		
77	vithin jiene. er tha the h		Elementary/Seconday (0-12) College (1-4 or 5+) Cas	e Practice				v Government		
פַ	filed valued val	Be	17. Father's Name (First, Middle, Last)	18. N	Mother's Name	(First, Middle, M	faiden Surnam	ne)		
<u>Xa</u>	ould be filed with and Mental Hygier is marked other tumatic event, the	욘	Paul Kenneth Taylor, Sr.		rgie M					
Maryland 21215-0036	should and Me is mar raumati			ailing Address (Street and No		Route Number, Vashino		State, Zip Code) DC 20009		
	1 and 2 should be if Health and Men item 27 is marke other traumatic			o 11th St.				- City or Town, State		
Baltimore,	Page 1 ment of 1 ant: If its ury or o		1 Meurial 2 Cremation 3 Removal from State	rematory or other place)	1	1		sport,PA		
≣	artme artme ortan injun		4 □ Donation 5 □ Other (Specify) Versal 21. Signature of Funeral Service Licensee	22. Name and Address of F	Facility T.at	nev's	Funer	al Home, Inc.		
Ba	permit. Page 1 a Department of H Important: If ite any injury or ott		CC0278	3831 Georg	ia Ave	e. NW V	Washin	gton,DC 20011		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not					Approximate Interval Between		
3	-hysician/		shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition	He CARRIE	nil ARr.	Jan A	Legas	Oncot and Death		
	Medical		resulting in death) a P Due to (or as a consequence of):	THE CHAIRMAN	77 / 1363	7126.2	13	7		
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	ate be executed physician and the burial tensit	dical								
760	icate phys	ledi	d							
(687	certif ending use a	an/R	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death	3 Ectopic pregnancy			23d. Da	ate of delivery		
Box	death le atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death	5 Other (specify)			M	onth Day Year		
P.O.	t the l	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in	Part I	220 Did tol	nacco lise con	ntribute to the cause of death?		
σ,	es tha igned be de	Completed by	Cerebral lu Fanction		T CIT I.			3 Probably 4 Winknown		
<u>10</u>	equire	etec	Coronary antery Dis.	2010		24a. Was a		. Were autopsy findings available		
တ္တ	has b	mp	Coronary antery 15:5.	enst		autops perfori	prior to completion of cause of med?			
ž	n: The ficate n, pag		Vascular Bementa 25. Was case referred to medical	26 Place of	of Death (Check	1 Yes	2 KNo	1 Yes 2 No		
Ita	sicial certi	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 XER/Outpa		,	me 5 Reside	ence 6 🗆 Oth	her (Specify)		
Division of Vital Records,	g Phy er this neral c		27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injury at		28d. Describe ho				
on	endin sath. or: Aft he fur	fica	2 Accident Investigation	M 1 ☐ Yes	2 🗆 No					
VIS.	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	1	28f. Location (St City or Town		ber or Rural Route Number,		
ō	pital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date	and place and	due to the cau	ee/e) and man	ner as stated		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial persist.	Medical	(Check 2 Medical Examiner: On the basis of examination and/or in only one)	vestigation, in my opinion, de	eath occurred at	the time, date an	nd place, and du	ue to the cause(s) and manner stated.		
	within to the comp	2	29b. Signature and title of certifier	29c. License num	nber	2	9d. Date signe	ed (Month, Day, Year)		
	P		Brullen work ra	Dol8	552		MARC	4312011		
			30. Name and address of person who completed cause of death (Item 23a) (Typ Rul A Davona MD 4233 Queen	e, Print)	1 14	74 .	u. A	Beech		
			31. Date filed (Month, Day, Year)	JS OUTY ICO	11190	117501	1147	42 20 13-		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5 2011	del.						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink Finaura All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 37. 2019 2:00 am Pik Fun Tong Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bethesda Montgomery Suburban Hospital If Under 24 Hrs. 8. Date of Birth Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Days March Day Months Min. Country) China 218-23-5019 81 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** 199 Rollins Avenue, 20852 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Asian Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Child Care Care Giver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Au-Yang Tong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4414 Muncaster Mill Road. Rockville, Maryland 20853 Vitus Cheng - POA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 04/11/2011 Silver Spring, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Signature of the pera Service Licensee 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Sepsis Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit ||A|| = |A|| = |A||Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End Stage Renal Disease, Clotted AV Graft. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Decubital Ulcer. Staphylococus Sepsis, Anemia, 24a. Was an autopsy performed? Yes 2 1 No Chronic Obstructive Pulmonary Disease 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D17656 March 31. 2011 ONE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Avenue, Suite 550, Chevy Chase; MD 20815 Tipaporn Woodward, M.D., 31. Date filed (Month, Day, Year)

APR 0 5 2011 Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Martha Barbara Scotia Foster Tompkins 19:27 M 2011 March 18, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clinton SOuthern Maryland Hospital Prince Georges 9. Birthplace (State or Foreign Country) North Carolina Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year 1 M 2 TX F Days Months Hours Min. **Director** 578-54-3021 ,1940 70 Apri Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington, DC 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20005 1425 N Street, N.W. USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 5th College (1-4 or 5+) Private Industry Counselor injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ pe Mildred Laws Naamon Foster permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 7907 Thrush Meadow PLace, Severn, MD 21144 APril S. Cephus/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Howard Thivers Medical School 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🎇 Donation 5 ☐ Other (Specify) 3/21/11 Washington, DC Signature of Funeral Service Licensee 22. Name and Address of Facility AUstin ROyster Funeral Home 20011 3821 14th STreet, NW, Washington, DC M00969 Leuton 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suckness cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Interco Immediate Cause (Final MOCGRAIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No for Pregnant at time of death Month Dav Year signed by the a 1 Yes 2 b g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? 2 🗌 No 1 Yes Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ဂ္ 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manyer of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 M Natural within 24 hours after death. To the Funeral Director: At 1 Tes 2 No Investigation 2 Accident
3 Suicide
4 Homicide Accident filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Completed file 🞖 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Day, Year) 2011

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:42 A M 2011 <u>James Allen Turner</u> Apri Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 12314 Funkshouser Rd. Clear Spring Washington County If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 82 Min Feb. 28 218-24-1459 1 XM 2 □ F Hours Marvland Director Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Washington County Clear Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ral", or items 23a or Examiner must be r Funeral 12314 Funkhouser Rd. 21722 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Butcher 10 Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Jesse James Turner Clara Agnes Unknown Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Day-Friend 12314 Funkhouser Rd. Clear Spring, MD 21722 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 4-15-2011 Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licer 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. diom Onset and Death Immediate Cause (Final Physician/ 2 M disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 NS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No cate has been signed by the atte page 2 should be detached for 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one, B B examiner's Other: 4 \(\sum \) Nursing Home Hospital 1 🗆 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending injury 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗖 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 0 6

DHMH 17 Rev 7/2009

Registrar

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year,

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		1- State of Maryland / Department of Health an Certificate of Death		giene Rag. No.			
		1. Decedent's Name (First, Middle, Last)	2. Date of De Month	ath Day Year	3. Time of Death		
Physic		CLARA L. TYLER	April	13. 201	1 4:45 P M		
/Med Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of C		4c. County of Deat	h		
		Alice Byrd Tawes Nursing Home Crisfield		Sc	omerset		
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Bir Min. (Month, Da	th 9. Birt	hplace (State or Foreign ountry)		
Director		220-26-3301 1 M 2 TF 94 Yrs. World S Days Hours	10/27	/1916 Peni	nsylvania		
and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
laryk	ō				1 ☐ Yes 2 No		
the N	Director	Maryland Somerset Ewell 10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?		
with Se or	٥	20903 Caleb Jones Road 21824		USA			
leath ns 23	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	? (Specify Yes or No				
DESILLIMOTE, INIGITY IGING ZIZIO-UUJO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show eny injury or other treumetic event, Ire Madical Examinative notified at	by Funeral	Armed Forces? If Yes, specify Cuban, Mexican, P 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No Specify: Year or Dates:	Puerto Hican, etc.)	Black, Whit	e, etc. White		
Z I Z I D-UUDO ad within 72 hours af giene er then "neturel", or tre Wedicel Esten	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	/Industry		
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and lame	5	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number of Print</i>)	or Rural Route Numb	er, City or Town, State,	Zip Code)		
and and balth n 27		Roger Evans (Son) P.O. Box 16 - Ta					
of H		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Iown, State		
Pag ment ent: ury c		'4 Donation 5 Other (Specify) Sunnyridge Mem. Park					
Dermit. Pages 1 ar permit. Pages 1 ar Department of Hea Importent: If item eny injury or othe once.		21. Signature of Fune Wiservice Licensee 22. Name and Address of Facility Mary Beth Bradshaw-Pruitt 306 W. Main St					
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	ardiac or respiratory a	arrest,	Approximate Interval Between		
Physician		Immediate Cause (Final disease or condition			Onset and Death		
/Medica	_	resulting in death) Due to (or as a consequence of):					
Examine		Comments that the constitution					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
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the death certificate be executed the death certificate be executed y the attending physician and to use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?		23d. Date of de Month	livery Day Year		
the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribute to	o the cause of death?		
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OT VITAL Physicien: Ti	Be	examiner?	f Death (Check only				
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To the Hospitel or Attent within 24 hours after deat To the Funerel Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and panel of examination and/or investigation, in my opinion, death and manner stated.					
thin 2 the mple	Meo	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	th, Day, Year)		
T will		200. Olgitation and this of territor	78-				
		20 Name and address of passes who completed assists of death (flow 22s) (Time Stript)	, ,	1000			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Vyay Kaumbunathan 201 Hall Hi	glucay,	4/13/11 Crist-eld	mD 2 (817		
S	tate	31. Date filed (Month, PROPER) 1 2014 32. Bigistrar's Signature	J 1/	<u> </u>			
Regis		31. Date filed (Month, PPRes) 0 2011 32. Bigistrar's Signature for Market					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH.G915,5/16/2011, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jacobo Baltazar Velasquez Month Physician/ Velasquez 0814 March aa 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Easton Hospital Memorial Talbot Baltaz If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1/08/1954 Months Guatemala 57 Director Usual Residence of Decedent or 28a-f shov 10a. State 10h County 10d, Inside City Limits 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at Director Jacobo 1[¥] Yes 2 □ No Talbot. MD Easton 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral or items 23a 511 August Street 21601 Guatemala 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. by 1 Never Married 2 Married 72 hours after 1 ¥ Yes 2 □ No White If Yes, Give Year or Dates Guatemalan "natural", Completed 3 Divorced 4 Divorced squez, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired)
Maintenance Elementary/Seconday (0-12) College (1-4 or 5+) Farming Be Maryland Jelasquez - Vela 18. Mother's Name (First, Middle, Malden Surname) Rumalda Velasquez Velasquez 17. Father's Name (First, Middle, Last) ပ္ Jorge Ruano Velasquez other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wilmar Arnoldo Velasquez Baltimore, Ma permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injuy or other trau once. 713 North Main Street Hurlock, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State
Tiquisate Escuintla
Guatemala 20a. Method of Disposition Date Cemeter, crematory of other place) Cemeterio Municipal 4/9/2011 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specifs) of Funeral Service Life yee ZHALLAGADS OR INALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Possible Sepsis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner infection of unknown etiology a consequence Sequentially, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Unknown signed by the a 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dependent diabetes mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 X No 1 Yes 2 🗌 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 X Yes 2 No Hospital: Other: မ 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this I in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural 5 \square Pending injury work 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) within 24 hours a To the Funeral C Medical X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 1144438995 March 29 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 3. Washington Street Easton, MD ZILOI ALEXANDER WIELAGRI M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 30 per DVR G914 4/20/11 dk
State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 ANTHONY VALIANT APRIL 2:35P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHARLOTEE HALL VETERANS HOME MARY'S CHARLOTTE HALL ST. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🛛 M 2 🗆 F Months Hours MAY 19, 1924 PENNSYLVANIA Director 100-12-0344 86 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD CHARLES PORT TOBACCO 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7505 PORT TOBACCO HILLS CT. 20677 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 K Married XYes If Yes, Give 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced WHITE Completed Year or Dates.W . W . II 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DANCE INSTRUCTOR 8 DANCE STUDIO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANTHONY VALIANT NELLIE RICCI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATRINA KEENAN/DAUGHTER 5507 MOON FISH CT., WALDORF, MD 20603 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State APRIN Burial 2 Cremation 3 Removal from State MD VETS • CEMETERY 18, 2011 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. . Signature of Funeral Se vice Lice M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 124 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALZHEIME Physician ISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal upon 4 ☐ Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERY Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform After this certificate 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🖵 No Other: 1 Inpatient 2 ER/Outpatient 3 DCA 4 Universing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 \square Pending 1 ☐ Yes 2 ☐ No Investigation after death Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of extifier 29d. Date signed (Month, Day, Year) 200 MD D0067788 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14090 HG Trueman Road, Suite 2300 Solomons MD 20678 RAO KODALT 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State APR 2 0 201 acked Registrar

DHMH 17 Rev 7/2009

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 30 hourse after about Division of Vital Records, P.O. Box 68760

		Please Type or Print in Black							
		Chate	partment of Health and Mental	Hygiene					
	1 - State Registrar Certificate of Death Reg. No. 2								
Physicia Medic		1. Decedent's Name (First, Middle, Last) Maryann C. Wetterau		of Death 3. Time of Death 4/4/2011 Year 0810 M					
Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death					
-		791 Harness Creek View DR. 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday)	Annapolis If Under 1 Year If Under 24 Hrs. 8 Date	Anne Arundel					
Funeral Director		148-38-2561 ^{1 □ M} 2√2 F 64 Yrs.		of Birth h, Day, Year) 1 / 1947 9. Birthplace (State or Foreign Country) NJ					
how at	ř	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits					
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Director		napolis	1 ☐ Yes & No					
or 28		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?					
23a 1st be	Funeral	791 Harness Creek View DR.	21403	USA					
tems er mu	Ē	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes o	r No- 14. Race - American Indian.					
or ii	by	1 ☐ Never Married 2XXMarried Armed Forces? 1 ☐ Yes 2 XXNo	If Yes, specify Cuban, Mexican, Puerto Rican, etc	.) Black, White, etc.					
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of He		20a. Method of Disposition 20b. Place of Disposition	osition (Name of Date	20c. Location - City or Town, State					
ant: I			Crematory 4/5/2011	Glen Burnie, MD					
spartr port y Inj		21. Signature of Funeral Service Licensee 2	2. Name and Address of FacilitHardesty	Funeral Home, P.A.					
∆ = a a	_	170 or Gran	12 Ridgely Ave. Annapo	lis, MD 21401					
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between							
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nding use a	<u>}</u>	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery					
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by the	Physician/Med	g Unknown 9 Unknown							
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ould k	ted .			1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown					
as be	Completed			Was an 24b. Were autopsy findings available prior to completion of cause of					
page	ا ا		1 🗆	performed? death?					
ertific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only one)						
this cal din	유 ::	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of	,	Residence 6 🗆 Other (Specify)					
After funer	Certificate:	Natural 5 Pending (Month, Day, Year) injury	f 28c. Injury at work? M 1 Yes 2 No	ibe how injury occurred					
ctor:	Ĕ	2 Accident Investigation 3 Suicide 6 Could not be A Homicide determined 28e. Place of Injury - At home, farm, st		ion (Street and Number or Rural Route Number,					
Direction by the property of t		4 ☐ Homicide determined 28e. Place of Injury - At nome, farm, st building, etc. (Specify)		on (Street and Number of Rural Route Number, r Town, State)					
neral d fille	ica I	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, and due to the	ne cause(s) and manner as stated.					
within 24 nous after deart. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination and/or inversionly one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at the time, o	late and place, and due to the cause(s) and manner stated.					
To t		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
\\ \(\)		I Shirt Sett Eden M. D.	D30701	4/4/11					
0,		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	,,					
,		Robert Scott Eden M.D.	2002 Medical Pkin	ythmapolis had zivoi					
State Registra	-	31. Date filed (Month, Day, Year) APR 0 5 2011	bank 1	,					
registra		Jenews B. Ag	an						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 1, 2011 8:51 A M <u>John Charles Weber</u> Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Huntingtown Caribbean Breeze Assisted Living . Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Aug. 19, **Director** 578-36-2005 ^{(eag}) 927 WasWington, DC 83 Usual Residence of Decedent or 28a-f show notified at 10b. County within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Calvert Dunkirk 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral USA 20754 12230 Longleaf Lane 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X X Yes 2 No
If Yes, Give ð 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates, 45-47 1 ☐ Yes 2X No Specify: Specify: White 3 XXVidowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) A & P Grocery Dairy Manager Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Marie Ella Schmitt John Frank Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12230 Longleaf Lane Dunkirk, MD 20754 <u>Denise</u> Barber/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Mary 120) Mary 120 Memorial Cemetery Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/05/2011 Laurel, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Rd. Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Immediate Cause (Final Physician 17 mon this disease or condition resulting in death) <u>Prostate Cancer with Metastases</u> Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Congestive Heart Failure Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Pulmonary Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Diabetes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? (2 2**X X**No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Nother (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XX Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide within 24 hours after death To the Funeral Director: / completed filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 139920 mohael ur 4-4-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hospital Drive, Suite 111, Prince Frederick, MD 20678 <u>John Michael</u> Brooks M.D.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 5 2011

32. Registrar's Signature

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26 pay Candee Marie WHITE March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 10819 Lincoln Avenue Hagerstown 8. Date of Birth (Month, Day, Ye Sept. 8 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Year 1 M 2 X F 43 Director Yrs 218-98-7374 1967 Usual Residence of Decedent 28a-f show 10b. County at 10a. State 10c. City, Town or Location Director items 23a or 28a-f s ner must be notified Maryland Washington Hagerstown 10e. Street and Number 10819 Lincoln Avenue 21740 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced "natural" Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Mail Clerk Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David McKinley Knode Dorian Kneisley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10819 Lincoln Avenue, Hagerstown, Maryland 21740 James J. White - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 and Department of Hamportant: If ite any injury or ot cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 3/30/2011 Rose Hill Cemetery ! 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home Calient Ola 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Colon disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ng physician and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant Ectopic pregnancy 3 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? for Pregnant at time of death P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. by Records. Completed 24a. Was an has page 2 autopsy performe certificate Yes 2 No I or Attending Physician: after death. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this and a ster death.

**Conneral Director: After the death of filled in by the first 27. Manner Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital 24 hours a Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature D0057989 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1-40 Broadway Baltimore 21231 401 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APRO Registrar

State of Maryland / Department of Health and Mental Hygiene.

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3. Time of Death 2011 a 2:00 4c. County of Death Washington 9. Birthplace (State or Foreign Maryland 10d. Inside City Limits 1 ☐ Yes 2 X No 10g. Citizen of What Country? USA 14 Race - American Indian Black, White, etc. Specify: White 16b. Kind of Business Industry Insurance 20c. Location - City or Town, State Hagerstown, Maryland Onset and Death Interval Between years 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 - For State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		• •					-	Are Legible	.
	-	For State Registrar	ate of Maryla		ertificate of E			Jiene Reg. No.2 ()	12770
Physicia Medic		1. Decedent's Name (First, Middle, Last) EARL	WH	INE			2. Date of Dear	th Day 2 ^{Year}	3. Time of Death
Examin		4a. Facility Name (if not institution, give street and number)			Location of Death	-	4c. County of De		
Funeral		310 Hamlet Circle 5. Social Security Number 6. Sex	7. Age (In vrs	s. last birthday		gewater I If Under 24 Hrs.	8. Date of Birth		e Arunde1 irthplace (State or Foreign
Director		577-20-1404 12 M S		Yrs.	Months Days	Hours Min.	(Month, Pay, 11/6/19	Year) Wa	shington, DC
/land f show ed at	tor	10a. State 10b. County	10c. 0	City, Town or L	ocation				10d. Inside City Limits
e Man r 28a- notifie	Director	Maryland Anne Arund 10e. Street and Number	el	Edgew	ater 10f. Zip Code			40- O''	1 Tes 2 No
with th 23a o ist be	erall	310 Hamlet Circle			2103	37		10g. Citizen of What 0	
items items	Funeral	11. Marital Status 12. W	as Decedent Ever in I	J.S. 13	. Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	14. Race - Am	nerican Indian,
after o	d by	1 Never Married 2 Married 1	☐ Yes 2 X No Yes, Give ear or Dates. 1941	-/18	1 ☐ Yes 2 🔀 No		, , , , , , , , , , , , , , , , , , , ,	Black, Wh Specify:	White
hours natura dical E	Completed	15. Decedent's Education (Specify only highest grade cor	n	16a. Dec	edent's Usual Occupa		do a	16b. Kind of Busines	
thin 72 ine. than " ie Med	mo	Elementary/Seconday (0-12) Co	ollege (1-4 or 5+)	life.	e kind of work done d DO NOT use retired)	uring most of work	arig	т 1 .1.	
ed wit Hygie other ent, th	Be C	12th 17. Father's Name (First, Middle, Last)		les	tman	18. Mother's Nam	ne (First, Middle, N		ne Company
d be fil Mental arked tic ev	ပ္	Roy White					che Rich		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland bing attreet of Health and Mental Hygiene. Important if firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Pri	,					City or Town, State, 2	Zip Code)
and 2 Health tem 2 ther t		Virginia White/ Wife 20a. Method of Disposition			Hamlet Ci			MD 21037 20c. Location - City of	or Town, State
Page 1 nent of int: If i		1 ☐ Burial 2 🌠 Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	cemetery, cr	ematory`or other place crematory	e) 4/4/		Edgewater	
permit. I Departn Importa any inju once.		21. Signature of Funeral Service Licensee			22. Name and Addres	s of Facility Geo	orge P. K	Calas Fune	ral Home
<u>6 5 5 6</u>		23a. Part 1. Enter the disease, or complication	ne that caused the de	ath Do not or				Edgewater,	
hysician/		shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	se on each line.	Stze		V De		±51,	Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a conse	equence of):)
sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury							
g physicia g the bur	dica	d							
attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If	yes, outcome of preg					23d. Date of d	elivery
the atter	Physician/Medical	in the past 12 months?	Live Birth 2 Fe Pregnant at time o Unknown		Cother (specify)	у		Month	Day Year
gnec gnec	þ	Part II. Other significant conditions contributed	in g to death but not r	esulting in the	underlying cause giv	en in Part I.			to the cause of death?
s been shoulk	Completed	Dicheter					24a. Was a	n 24b. Were a	utopsy findings available
ate has	Som						autops perform 1 Yes	med? _ death?	es 2 No
cran: certific ector, I	Be	25. Was case referred to medical examiner?	al:		26. Pla	ace of Death (Chec	k only one)		
r this c	e: To	I □ Yes 2 INO	1 ☐ Inpatient 2 L a. Date of Injury	28b. Time	of 28c. Injury	4 □ Nursing He at		ence 6 Other (Spe	ecify)
ending sath. or: Afte	ficat	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury		? Yes 2 □ No			
al or Au s after de l Directo	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	e. Place of Injury - At building, etc. (Spec		treet, factory, office		28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
to the hospital or Attending Physician: the law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check 2 Medical Examiner: Or only one) 3 Certifying Nurse Prac	the basis of examinat	ion and/or inve	estigation, in my opinio	n, death occurred a	it the time, date an	d place, and due to the	e cause(s) and manner stated
vithir To th		30. Name and address of person who comblet 31. Date filed (Month, Day, Year)							
1 JULY		30. Name and address of person who completed the complete of t	ed cause of death (Ite	em 23a) (Type. U 4 1	POEFENS	E HWY 1	ANNA	POLY MY	1401
Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	ha. N. I				
Registra	ir -	MINUZZUII	peneur	ja. ja	paire				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar MEND#24a+b+26perMD, 4/6/11; BWW, McCoCertificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 27, Day 2011 Year Mark Weiner 8:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** 1 X M 2 □ Days Hours Min 130-40-5910 62 01/19/25 921 99219 F16mma **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Montgomery Silver Spring 1 X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11620 Kemp Mill Road 20902 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David Weiner Norma Berry 19a. Informant's Name/Relationship (Type, Print)
Cheryl Elder-Social Worker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
401 Hungerford Drive 2nd Floor Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town. State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Chesed Shel Emmes Cem. 4 Donation 5 Other (Specify) 3/31/201 Capital Heights, MD 22 Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 Signature de mara Service Ticensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, Examine Date to for as a consequence of cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician of for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Pregnant Pregnant at time of death 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? After this certificate 1 ☐ Yes 2 V No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA me 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation within 24 hours after death

To the Funeral Director: of completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) e 01 EN 10050410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

11. Mar

0 5 201

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 30, Day 2011 Year Elizabeth Ann Wineberg 21:08Р. м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 577-40-7655 1 □ M 2 🗓 F 79 Days Hours Marth 1984, 1932 Washington, DC **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Maryland Prince George's Bowie Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2501 Kagwood Lane 20715 United States items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Univ. of Marvland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clinton Burnett Amy Hieskell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Creasey -daughter 5006 Edgewood Road College Park, Maryland 20740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 4/9/2011 Brentwood, Maryland 21. Signature of Funeral Service Licens Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Man Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transi an wente Myocandial inform Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box 13 the Hospital of Attending Physician: The law requires that the death of 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth
Pregnant:
Unknown signed by the at the detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy Yes 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 TYes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of Injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Acciden injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier (Check Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Takoma Park, 7600 Caro 31. Date filed (Month, APR 05 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 26 per DVR 1914 1921 Fraker All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 March 27 215 PM KOOK Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Angels Garden Assisted Living Rockville Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign NY Country) Days Hours 8/15/1935 Director 577-52-5762 Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD North Bethesda 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5904 Dorchester Way 20852 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 3 Nidowed 4 □ Divorced If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. White Completed er than "natura, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Page 1 and 2 should be filed within iment of Health and Mental Hygiene. Fant; If item 27 is marked other than ury or other traumatic event, the Merican or other traumatic event, the Merican and the management is the Merican and the management in the Merican and the management is the Merican and Merican an Elementary/Seconday (0-12) College (1-4 or 5+) Administrative US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Winfield Wagner Maybelle Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Jamie Wollard - sister in law 5904 Dorchester: Way North Bethesda MD 20852 20b. Place of Disposition (Name of Gate of Transfer of The Transfer of Cemetery 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 3/30/2011 Silver Spring MD 21. Signature of Funeral Servi 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels 175
1170 Rockville Pike Rockville MD 20852 M01163 23a Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Examiner Due to (or as a conseque Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that the death certificate be executed resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year No 9 Unknown Other significant conditions ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, To the Hospital or Attending Physician: The law requires No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an perform After this certificate 2 🗌 No 1 Tes the Funeral Director: After this certificated filled in by the funeral director, of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Assisted Living 2 Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number SAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lintercum. Dia State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** March 30, Day 2011 Year Bruce Wallace 1:00 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 3, Birthplace (State or Foreign Country) **Funeral** 579-32-7177 Months Days Hours 1**X** M 2 □ F 84 Director North Dakota Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mayfort Examiner matter and angone. Maryland Calvert Prince Frederick Director 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5390 Sandy Point Road 20678 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: þ If Yes, Give 1944-1946 Year or Dates: 1944-1946 White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (012) College (1-4or 5+) Security Guard Nations Capital/Garage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Donald Kenneth Wallace Effie Martin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Wallace Robinson - Niece 10910 Bond Road Adelphi, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 4/1/2011 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA Narell 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherodeletotic Cordiovascular dispose disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertensive Cardio Vascular Disease Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. the 9 Unknown þ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ò Hyperlipidemic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Sicie Sinus Synchrome 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has page 2 autopsy performe The certificate Dementic 2 🖪 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Division 1 Natural 5 Pending death. after death Director: / 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral D letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 50653 - an-3-31-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C. KNASSUIZ Deale C murchton Road Deaie 32 Registrar's Signatur State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DUNG Month 2/21 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 1525 Farlow Ave. Crofton Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Washington, DC Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 1 M 2 F Months Days Hours No. 1943 Min. **Director** 67 578-58-5167 Usual Residence of Deceder or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1X Yes 2 No Maryland Anne Arundel Crofton 5 10e. Street and Number 10f. Zip Code ıral", or items 23a oı I Examiner must be 10g. Citizen of What Country? with 1 Funeral 1525 Farlow Ave. 21114 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumation. Secretary Wyatt Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Harold Sewell Agnes Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren Young/Husband 1525 Farlow Ave., Crofton, Maryland 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Pemoval from State Baltimore-Washington 4 ☐ Donation 5 ☐ Other (Specify) 4/5/2011 Laurel, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. TONEA R disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Pregnant at time of death Month Year the 9 Unknown 9 Unknow cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No eral Director; After this certificate I filled in by the funeral director, page 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Praction to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of ce tifier 29c. License number W on pleted cause of death (Item 23a) (Type, Print) MDZIKO

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Registrar

31. Date filed (Mo.

egistrar's Signature

5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 29, Day 2011 Year Physician/ 1035 PMM Но Yoo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**□M 2 □ F Months Days Hours Min 0973071935 South Korea 75 Director 212-96-7824 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Examiner must be notified at Bethesda MD Montgomery 1 Ty Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a United States 10250 Westlake Drive #503 20817 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Korean If Yes, Give Year or Dates 1 Yes 2 XNo Specify: "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Janitor Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dae R. Yoo Deung B. Song 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Sang Yoo - son 4676 Carisbrooke Lane Fairfax, VA 22030 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Norbeck Memorial Park 4/2/2011 Olney, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc II70 Rockville Pike Rockville MD 20852 M01163 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, phock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Bilateral Pneumonia Sequentially list conditions, if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Year Pregnant at time of death 2 🗌 No 9 Unknown g 🗌 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? certificate 1 ☐ Yes 2 ☐ No Yes 2X No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 X No 읻 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending I 24 hours after death. 1 X Natural work? injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) layonti Pare 10052586 3/30/11 completed cause of death (Item 23a) (Type, Print) vatel 1500 Forest Glen Road Silver Spring, MD 20910 dress of person who complete Lalbhai Patel 31. Date filed (Month, Day, Year) 32 Registrar's Signa

DHMH 17 Rev 7/2009

Registrar

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3/29/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 31 2011 Elda March 8:10 A.M Lois Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) Feb. 17, 1926 West Virginia **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Hours Director 85 578-28-5965 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Village Montgomery 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 9608 Horizon Run Road 20886 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Banker Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Ryan Flossie Linville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ayers T. Yates/Spouse 9608 Horizon Run Road, Montgomery Village, MD. 20886 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) 3/31/2011 Metropolitan Crem. Alexandria, Virginia 21- Signiture of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home .O East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final acute Onset and Death Physician/ arrh thmia disease or condition resulting in death) 6 hours Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate rathe. Finer Underlying Examine Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Kunknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy death? 2 2 No 2 No Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐No Other မ 1 Inpatient 2 XER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed Certiffing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [29b. Signature and title of 29d. Date signed (Month, Day, Year) W() 0068488 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, Medical Center Drive, 9901 Lrwin, MD 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. em 19a per F.p. 04/11/2011 Carroll Co., will State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Year Month 27 pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Dove westin ins Carrol 0050 Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** Month, Day, Year) Days Hours Min 1 X M 2 🗆 F 213-36-3694 Director 70 Aug. Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Carroll Hampstead 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3933 Sunset Drive 21074 United States n "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: white Completed 3 XWidowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) equipment operator highway maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Alfred Zimmerman Lillian Eva Lindeman 19**保付付金工的**和KRela**为行动in(在在记行, Jr . / Son** 9b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard L. Simmerman, Jr./son 3933 Sunset Drive Hampstead, Maryland 21074 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 5 1 X Burial 2 Cremation 3 Removal from State Hampstead Cemetery Hampstead, Maryland 4 Donation 5 Other (Specify) 2011 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee 934 South Main Street M01072 Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician/ cellular Ċ disease or condition resulting in death) 919 to 5/2/6 Medical Due to (or as a consequence M Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 2 No 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has the funeral director, page 2 s autopsy performed 1 Yes 24 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and Title of certifie 29c. License number 29d. Date signed (Month, Day, Year, si 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Rice, M.D. 555 South Center Street Westminster, MD 21157 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death .^{Day}2011 Physician/ April 18, Marilyn Jean Anderson 2:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hyattsville 4014 Nicholson Street Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours (Month, Day, 1) une 13 1938 New York **Director** 113-30-0629 June Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10d. Inside City Limits 10c. City, Town or Location Director 1 🔀 Yes 2 🗌 No Prince George's <u>Hyattsvi</u>lle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4014 Nicholson Street 20782 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 14 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes. Give Specity: White Completed 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) Raymond Anderson Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9151 West Greenway Rd. #230 Peoria, AZ 85381 Bonnie Fowler/friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Final Journey Crematory 04/21/2011 Woodbine, MD 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Gilly Homes Cremation Service P.O. Box 784 21029 MO1251 Beverly L. Heckrotte, P.A. Clarksville MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner cause (Disease or iinjury Due to for as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d Date of delivery 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 9 Unknown Unknown þ, been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed iis certificate has been si director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 No a 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending Natural injury Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D

Registrar

State

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar		artment of H		Mental Hy	giene (Reg. No.		12781		
	Physic	an	1. Decedent's Name (First, Middle	A 1				2. Date of De		Year	3. Time of Death		
	/Medi		BABY BO	1111				03	30	2011	1630 PM		
	Examir	ner	4a. Fecility Name (If not institution	11 -1		4b. City, Town, or			4c. C	ounty of Death			
	Funcion		5. Social Security Number	6. Sex 7. Age (In yrs.	last hirthday)	If Under 1 Year	IM ORE		th	0 Bidba	lace (State or Foreign		
	Funeral Director		infant	1₩ 2□F	Yrs.	Months Days	Hours Min		^{y, Year)}	.1 Ma	ryland		
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County	140.00									
	ehov ehov	_	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation Ltimore				1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No		
	286-1	Director	10e. Street and Number		Dal	10f. Zip Code			10= 04=		-		
	72 hours after death with the Maryland natural', or items 23a or 28e-f ehow lical Examinar must be notified at		922 E. Patapso	co Avenue			225		Tog. Chize	on of What Coun USA	•		
	deatl	by Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of Hi	ispanic Origin? (5	Specify Yes or No)- 14	I. Race - Americ			
36	or ite	y Fu	1 X Never Married 2 ☐ Marri	ed 1 ☐ Yes 2 ☑ No		fYes, specify Cuba I□Yes 2)(∑INo	n, mexican, Puer Specify:	to Hican, etc.)		Black, White,			
Ö	72 hours natural',	q pe	3 Widowed 4 Divorced	Year or Dates:						pecify: bla			
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pu	be filed ital Hygi of other event,				17. Father's Name (First, Middle, I			unk	18. Mother's Na	me (First, Middle,			
yla	should be nd Menta nmarked umatic ev							ce Adair					
Maryland 21215-0036	2 6 9 10	H	19a. Informant's Name/Relationsh Harbor Hospital			g Address (Street a							
	s 1 and of Heelth item 27 other tr		20a. Method of Disposition			S. Hanov	ver Stre	et Balti			25		
Baltimore,	Pa Pa		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (Sc	3 □Removal from State coecify in state	emetery, cren	natory or other place	9)	Suito	200. 200	ation - City or To	wn, State		
Balt	permit. Pa Departmen Important eny injury once.		21. Signature of Euneral Service I	Drector	; 22 S B	Name and Addres tate Anat altimore,	s of Facility Comy Boa	rd 655 W	. Bal	timore	Street		
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused the death	n. Do not ente	er the mode of dying	g, such as cardia	or respiratory a	rrest,		Approximate Interval Between		
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	/Medical Examiner		resulting in death)	Due to (or as a consequ			/						
		_	Faquantially list conditions if any, leading to immediate cause. Enter Underlying										
	uted Insit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):										
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	artifica ing ph as th		IF FEMALE:		_								
Вох	leath certifi attending a for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnal	death 3	Ectopic pregnancy			23	d. Date of delive	•		
o	The lew requires that the death cert are hes been signed by the attending page 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5□	Other (specify)				Month	Day Year		
۳.	that hed by deta	y Ph	Part II. Other significant condition	ns contributing to death but not resu	ulting in the un	derlying cause give	n in Part I.	23e. Did to	obacco use	contribute to the	e cause of death?		
Division of Vital Records, P.O.	quires in sign	Ω						101					
ပ္က	ew re	Completed						24a. Was	an :	24b. Were autop	sy findings available		
ř	The I	EO			·				rmed? 2020No	prior to con death?	prior to completion of cause of death?		
IIa	ding Physician: The lev h. After this certificate hes funeral director, page 2	Be	25. Was case referred to medical examiner?				26. Place of Dea	1 ☐ Yes ith (Check only o	/	10 163	2 00 No		
5	hysic this co	ို	1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2 1	ER/Outpatient		4 Nursing n	ome 5 Resid	lence 6 [Other (Specify)		
ב	After Funera	on	27. Manner of Death 1 Natural 5 ☐ Pending		28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury o	occurred			
200	ten deat tor: the	licat	2 Accident investigation 3 Suicide 6 Could not be determined 5 Homicide 5 Suicide 4 Homicide 6 Homicide 6 Suicide 6 Homicide 6 Suicide 7 Suicide 8 Suicide 7 Suicide 8					24					
2	a after i Dire	Certification:						vumo u r or murai	Houte Number,				
	Hosp 4 hou Fune ely fill	edical	29a. Certifier 1 Certifying (Check only one) 4 Medical E	Physician: To the best of my know xeminer: On the basis of examination and manner stated.	wledge, death ion and/or inve	occurred at the time estigation, in my opi	e, date and place inion, death occu	, and due to the or	cause(s) ar	nd manner as sta ace, and due to	ited. the cause(s)		
:	vithin 2 To the Complet		29b. Signature and title of certifier	A A A A		29c. License				signed (Month, E			
			Mmon	MI WWG		1768	571			30/2			
			30. Name and address of person w	ho completed cause of death (Item	23a) (Type, P	rint)	-11			(,		
			HUMMA ISI	HAGTIWANA 3	3001	South H	ANOVE	R STRE	EET				
,	Stat Registra	~	31. Date filed (Month, Day, Year) APP 9.1 201	32. Registrar's Signati	harke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per ANA BD G915 5/02/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Month Physician March 27, 9:40 PM M Nicholas V. Arcinese /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cecil 36 Oak Avenue Earleville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth (Month, Day, Year)
Feb 5, 1924 7. Age (In yrs. last birthday) **Funeral** Months Hours Davs 1 M 2 □ F Director 87 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Wedical Examination withhold 1 ☐ Yes 2X No Director Earleville Cecil MD 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 23a or USA 21919 36 Oak Avenue 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∑Yes 2 □ No
If Yes, Give
Year or Dates: 43-46 1 Never Married 2 Married Saltimore, Maryland 21215-0036 white 1 □Yes 21☑No Specify: Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trailmetin. Elementary/Secondary (0-12) College (1-4or 5+) granite quarry rock processor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Millie Arcinese Albert Arcinese ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 Oak Avenue Earleville, MD 21919 19a. Informant's Name/Relationship (Type. Print) Barbara Scott/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) ure of Fur and Straice dice Made, Director State Andresmy Facility and 655 W. Baltimore Street Baltimore, MD 21201 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alherescleratio Hear FDI Seese **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner typertension 4@xs Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or at a consequence of): Examine law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? 1 Yes 2 No certificate e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier cal completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier Sachder SMD 10023322 4.13.2011.

Registrar DHMH 17 Rev 1/2001

State

E thigh St, Eletin MD 21921.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SACHDEN MO

126 A,

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, physician

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

1 and 2 should be filed within 72 hours after whealth and Mental Hygiene. em 27 is marked other than "natural", or Itel

item 27 i

Department of H Important: If ite any Injury or otl Pages 1

Saltimore, Maryland 21215-0036

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

APRIL 18, 2011

29d. Date signed (Month, Day, Year)

State Registrar

ASHA SHETH 3001 S. HANOVER ST BALTIMORE, MD 31. Date filed (Month, Day," Year)

24 hours after death Funeral Director:

To the Hos within 24 ho To the Fun completely

1041

filled in by

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number RESGOI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 18, 2011 ear 11:46 AM Betty B. Allen Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth
(Month, Day, Yes Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days 1 □ M 2 🗓 F Hours **Director** 023-28-6859 80 October Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director Maryland Montgomery 1 Yes 2 X No Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20850 9801 Veirs Drive #1 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herbert LaGard Bonnet Edith Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Amy Soderstrum / Daughter 4055 Sand Trap Court, Mount Airy, Maryland 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 20. cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 1 Durial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Inc. Bethesda, Maryland Signature of Yun 1915 your Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, In 7557 Wisconsin Avenue, Bethesda, Maryland 20814 MO1619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death bilateral Ph sician/ oneu monia disease or condition resulting in death) Medical Due to (or as a consequence of): Examine myo cardial acute Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed hypoxia Cause (Disease or iinjury respira attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical cardiomyopa Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 M Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? within 24 hours after death.

To the Funeral Director, After this certificate 2 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗷 No မ 1 Tes 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Certificat 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D00052557 Abebe mare 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Amare Abebe, MD 31. Date filed (Month, Day, Year)
APR 2 1 2011 32. Fegistrar' Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 4 Day 14 Physician/ AIDOKO -300 tage Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard Columbia Howard County General Hospital 8. Date of Birth (Month, Day, Year, Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Hours 6 Months Days Min. Director none MD DMJ14 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d, Inside City Limits 10c. City. Town or Location Director MD Anne Arundel Laurel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20724 8052 Pennington Dr. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Infant Infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Atai Aidoko Ali Agwuye Heidi Ogbadu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8052 Pennington Dr. Laurel, MD 20724 Agwuye Adoko Ali mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Columbia Memorial Park Apr 19, 2011 Clarksville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 ature of Funeral Service Licenses 23a. Part + Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death be detached signed by the Unknown 9 Unknown 2011 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy After this certificate has 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Homari Be Hospital Other: မ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 17 ay 2011 a 1:05 A M Eleanor Bradley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rockville Montgomery Casey House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min Massachusetts 038-30-9845 1951 Director 59 Usual Residence of Decedent 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Montgomery Potomac 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9738 Pleasant Gate Lane 20854 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White "natural" Completed 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Legal Publishing Lawyer Be filed ent of Health and Mental Hat: If item 27 is marked ot yor other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert Bradley Eleanorose Boyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trace once. Samuel Bradley/son 9738 Pleasant Gate Lane Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 04/19/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final .Physician/ disease or condition resulting in death) a. Cervical Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underly in Cause (Disease or linjury Due to (or as a consequence of): this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Dav Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 XNo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) hospice 27. Manner of Death 28a. Date of injury e Hospital or Attending Pl n 24 hours after death. e Funeral Director: After th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No М ☐ Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature and title of certife 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Coleman, M.D.

6001 Muncaster Mill

32 Regionar's 96 lattire

D37142

Rd. Rockville, MD 20855

April 17, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 16, 2011 4:00A M Spottswood Bird Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 2814 Kaywood Place Eldersburg Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours (Month, Day, Country) Virginia **Director** 212-18-2524 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No MD Carroll Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a Examiner must be Funeral USA 2814 Kaywood Place 21784 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agent Insurance marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fill Health and Mental ည Spottswood Bird Edna Wallis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t; If item 27 i William R. Bird/son 5251 Ilex Way Dayton, MD 21036 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important; If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 4/20/11 Woodbine, MD 21. Signature of Funeral Service Licenses Göing Moneschemation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the Assass, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ a. Malignant Melanoma disease or condition Medical resulting in death) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has or Attending Physician: The this certificate 1 Yes 2 No Yes 2 XN hours after death.

uneral Director; After this certifle
of filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗓 No Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 🛚 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral L Hospital Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37606 April 19, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6190 GEORGETOWN Blud. Eldersburg MD 21784 ChIERMAN III

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 18, Day 2011 Physician/ 2:20 P M Karen Kay Bath Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 80 Dendron Court Baltimore Parkville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Days Hours Jan. 8, 1952 1 □ M 2 🗓 F 59 478-70-6404 **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 🗌 Yes 2 💢 No Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 80 Dendron Court 21234 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 🕅 Never Married 2 🗆 Married Completed by 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Credit Manager Black & Decker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John A. Bath Virginia Hope Barnard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Betsy Jayne (Sister) 3523 SW 37th St., Des Moines, IA 50321 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 41 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Grandon Funeral and Cremation Care 414 Lincoln Way, Ames, Iowa 50010 21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ Artenoscientic Cardiovasula Discare disease or condition resulting in death) Medical Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to jor as a consequence of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Viabeter Mellitus type II Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed O Sesity 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No death? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Kesidence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 🛚 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 21 APRIL ZOLL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mare I. Leavey ui) 1734 York Road 31. Date filed (Month, Day, Year) 32. Registrar's Sign Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 0653 M wan nerine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Anne Arudel Medical Center Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. April Day Year) 1927 Virginia Director 227-30-2091 83 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2700 South Haven Road U.S.A. 21401 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: 3 ₺ Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Elton Sanford Georgia Annie Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Bowen 3512 Majestic Ln., Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory, or other place)
Rappanannock 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4/16/2011 Warsaw, VA 4

✓ Donation 5

☐ Other (Specify) Babtist Name and Address of Facility elch Funeral Home-Montross 7546 Kings Hwy., Montross, 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line ceduac Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Dav Year 1 ☐ Yes ≥ ₩ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Trive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 LNo Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After i completed filled in by the funera Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and time Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ McMullen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛭 F Days Min. Month Day, Year) 29 North Carolina Director 224-28-2215 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norified. Once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Washington Fairplay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17109 Spielman Road 21733 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Manager Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Henry Foster Viola Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Beacham / Daughter 17109 Spielman Road, Cockeysville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 🛮 Donation 5 🗆 Other (Specify) 04/18/2011 Anatomy Gifts Registry Hanover, Maryland 21. Signature of uneral Service Licen 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. Ρ, Hanover, 21076 23a. Part 1. Enter the disease, as complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Myo Cordial disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner trace Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a donsequence of): and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Monced Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been significant 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate l ☐ Yes 2 No 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita Other: 1 ☐ Yes 2 🌠 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this if in by the funeral director 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Matural Natural injury 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours 1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 4656

Registrar

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32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S1. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19^{Day}2011 April Physician/ 8:00p м Brocato Sophie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1252 Delbert Avenue Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 1 F Months Days Hours Min. (Month, Day, Maryland 98 219-03-0292 Director Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director N/A Baltimore MD 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21222 USA 1252 Delbert Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black White, etc. 1 Yes 2 No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White "natural", 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home 6 N/AHomemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဂ္ Casimir Dopkowski Mary Goldys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1252 Delbert Avenue Baltimore, MD 21222 Elaine Kowalewski-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Stanislaus Cem. 4-26-11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Rome, 21. Signature of Funeral Sen 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Vasinlar after oxcus u Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death this certificate has been signed by the a ral director, page 2 should be detached 1 ☐ Yes ∠ ■ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 🛛 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) To the Hospital or Attending Pleath: Within 24 hours after death.

As the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying/Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signaty 29d. Date signed (Month, Day, Year) April 20, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W 1734 mul M 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Braddy April 1 Pay Physician/ Juanita Μ. 2011 5:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 1100 Ovens Road, #211 Oxon Hill 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** Country) D.C. 1 □ M 2 🗶 F Months Days Hours Min (Month, Day, 84 ∜926 Director 578-30-5174 iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Oxon Hill Prince George's 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with #211 20745 U.S. 1100 Owens Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 African-American 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 XWidowed 4 ☐ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Child Care Provider Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Brown Mary Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Morris B. Chestnut-Nephew 2018 Peabody Street, Hyattsville, MD 20782 altimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4-22-11 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Pk Crematory Nnature of Funeral Service Licensee 22. Name and Address of Facility Bonnette & Assoc. Funeral 2504 28th St., N.E., WDC 20018 A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Inmediate Cause (Final Physician/ disease or condition resulting in death) Connestive Heart Failure Medical Due to (or as a consequence of) Examiner Cardiac Arrest Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Physician: The law requires that the death Day Year Pregnant at time of death signed by the a d be detached for Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has loompleted filled in by the funeral director, page 2 s performe 1 ☐ Yes 2 ☐ No Yes 2 XNo Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🛛 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7.19.11 ussan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hassan Bushehri MD 1328 Southern Ave., S.E., Ste. 201, WDC 20032 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Physician/ 520A M drea APRIL 2011 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** County of Death 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth Birthplace, Country) m/ **Funeral** 1 M 2 M F Hours Min. **Director** Usual Residence of Decedent 10a. State 10b. County with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21328 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No þ 1 🗌 Never Married 2 🗌 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 ₩Widowed 4 □ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam မ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Method of Disposition 20b. Place of Disposition (Name of 20c. Location - Cite ematory or other place) ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Greene Funeral Sarvices 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBSTRUCTIVE PULLISMANY Pnysician/ DISEASE HRONI C disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examine Dus to (or as a nonequents of If any, leading to himself cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NELLIMS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours after death. Funeral Director: After this certificate has page 2 performed) MA 1 Yes 2 No Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🗷 No Other: ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28b. Time of 28d. Describe how injury occurred 5 \square Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00056948 FITEND ING APRIL 19 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 54 Physician/ ambertien bunting Medical Butmore 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** ^{Year)}1923 Months Days Hours June 13, 1 🔀 M 2 🗆 F Maryland Director 87 216-12-2768 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nahum" any highy or other traumatic and other traumatic and other traumatic and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21214 5107 Crosswood Avenue U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Completed by 1 ☐ Yes 2 K No Specify. Specify: 3 X Widowed 4 ☐ Divorced White WW II Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Tile Setter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဂ Pitcher Bell Bunting Bertha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2908 Crystal Palace Lane Richard L. Bunting, Jr. Pasadena, MD Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 x Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Cem 4/22/2011 Owings Mills, MD 11824 Reisterstown Road 22. Name and Address of Facility 21136 ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events Due to (or as a consequence resulting in death) Last physician by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ঠ Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 🗙 Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of De h 28c. Injury at 28d. Describe how injury occurred Certificate; 1 Natural 2 Accident (Month, Day, injury 5 Pending work? 1 ☐ Yes 2 ☐ No M Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signal

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State Registrar Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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2011

Up 21201; Elizabeth K. Smelter, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Cottman Sr. Charles April 17 2011 7:38 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Long Green Center Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1**X** M 2□ F 212-22-2294 3 09/10/1927 MARVIAND Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 1 Yes 2 No item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified BALTIMORE Director MD 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21215 6980 MARSUE Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Timed Forces? UN KNOWN
1Deres 2 □ No
If Yes, Give
Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK Saltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. d 2 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) DRIVER HNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARSUE DR. BALTIMORE MARYIAND 212/5

on (Name of Date 200. Location - City or Town, State Department of Health a Important: If item 27 is any injury or other trains SON CHARLES COTTMAN 6980 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATORING 04/20/2011 BALTIMORE, MARYIAND
22. Name end Addr so of Facility The DERRICH C. JONES FIH, P. A. 1.
4611 PARK H9+5, AVE., BALTIMORE, MARYIAND 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approx ate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) NOT KNOWA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sone equation of) The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 ANCMIA 4 Unknown 1 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No certificate or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death Check onl one Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0047056 30. Name and address of person who co npleted cause of death (Item 23a) (Type, Print) Butst

Registrar

State

31. Date filed (Month, Day, Year) APR 2 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 2011 Centerfeit April 16 1:15 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Calvert Prince Frederick Calvert County Nursing Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Days Hours Months 1 ★M 2 ☐ F 08/24/1928 578-30-3710 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 X No MD Calvert St. Leonard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6562 Long Beach Drive 20685 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Core Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Centerfeit Florence Edward Charles Ostrander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Centerfeit / Wife 6562 Long Beach Drive, St. Leonard, MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 04/20/2011 Hanover, Maryland 4 ⊠Donation 5 ☐ Other (Specify) 21. Signature of Fune Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung
Due to (or as a consequence of): ancer Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Examiner attending physician and for use as the burial-transit the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After this funeral dir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

/Medical

Physician

/Medical

Directo

by Funeral

Completed

Be

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Examine

Physician/Medical

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Completed

Be 2

Certification:

Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, Tile Martical Expenses.

Chronic	obstructive	1 ☐ Yes 2 ☐	1 Yes 2 No 3 Probably 4 Unknown					
Renal i	ntubliciency			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
25. Was case referred to medical	26. Place of Death (Check only one)							
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3 □ DO	Other: 4 Nursing H	ome 5 Residence 6	Other (Specify)			
27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	lb. Time of Injury M	Bc. Injury at Work? 1 Yes 2 No	28d. Describe how injury				
3 Suicide 6 Could not determined		e, farm, street, factory,	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	hysician: To the best of my knowle							

29c. License number

GYAN

Rood

50653

29d. Date signed (Month, Day, Year)

SURANA

Deale m.D

4-18-2011

State Registrar 5851 -

-C .

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ayan



Surono.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 JOHN D. CLARK 2011 9:42 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Capitol Heights 5619 Coolidge Street If Under 1 Year I If Under 24 Hrs. Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) VA 1 🛛 M 2 🗆 F Days Director 228-52-1504 71 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Examiner must be notified 1X Yes 2 ☐ No Capitol Heights Prince George's 10e. Street and Number 10g. Citizen of What Country? Funeral "natural", or items 23a 20743 USA 5619 Coolidge Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Private Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Queen Esther Craft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5619 Coolidge St. Capitol Heights, MD 20743 Nannie Clark/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 \square Cremation 3 \square Removal from State 04/21/2011 Brentwood, MD Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 4 Ocset and Beath Physician/ Anaplastic Astrocytoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury or Attending Physician; The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal Geath ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year should be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy To the Hospital or Attending Proyswar... within 24 hours after death.

To the Funeral Director: After this certificate! performed^a death? 1 Yes 2 X No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🕝 Yes Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 04/19/2011 H0058032 Sulliams, DO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Cynthia M. Williams 3720 Upton Street NW Washington, DC 20016 32. Registra Signatur

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 2011 6:20 PM M Marjorie H. Cyphers March 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore 5. Social Security Number Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 - M 2 X F Hours Min Dec 23, Year) Months Days Mary land 89 Yrs Director 218-18-5656 Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Funeral Director** ms 23a or 28a-f s must be notified 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 6726 Glenkirk Road 21239 filed within 72 hours after death 12, Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify. white Specify: "natural" Completed 3 X Widowed 4 □ Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. 12 <u>healthcare</u> secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harry Purdy Margaret Wilburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is i Suzanne Cyphers/daughter 913 Rappaix Court Towson, MD 21286 Department of Health Important: If item 27 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Qther (Specify) State and Andrean yaciBoard 655 W. Baltimore Street 21. Signature of Funeral Savice Licenses Director 21201 Baltimore, MD Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (o) as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or iinjury Due to as a consequence of) requires that the death certificate be executed ng physician and as the burial-transi W. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death signed by the a Unknown 9 [Linknown . Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Tes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending s after death. 1 Tes 2 No Accident Suicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 only one Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Box 68760 P.O. Records, Hospital or Attending Physician: 24 hours after death. Division of Vital 24 hours

> Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 4105, Baltimore, MD 21204 State Registrar

29b

anature and tit

certifier

00071187

29d. Date signed (Month, Day, Year)

3 31 11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Patricia I. Cromer 7:05 A M April 2011 Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min (Month, Day Year) -21-1940 1 M 2 J 217-38-1210 70 Yrs. Director MD Usual Residence of Decedent 28a-f shov 10b. County aţ 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Examiner must be notified Baltimore Baltimore 1 Yes 2 X No 5 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3 Cypress Lane 21220 USA 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married ☐ Yes 2 ☐xNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: White "natural" 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumant. Elementary/Seconday (0-12) College (1-4 or 5+) House Cleaner Domestic Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Hess Dorothy Hess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cypress Lane, Baltimore, MD 21220 David Merrill - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) Glen Burnie, MD -20-11 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility nature of Funeral Service License Bradley-Ashton Funeral Home 2134 Willow Spring Road, PA, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Approximate** nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, loading to in module cause. Enter Underlying Cause (Disease or iinjury that initiated events Dist to (or as a nonesquence or) and -transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a the burial-/Medical I Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death 2X No ed by the a detached f 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perfor certificate ! 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 **X**-No 4 Nursing Home 5 Residence 6 Other (Specify) HOS BECK မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 ☐ Yes 2 ☐ No death. Investigation 6 Could not be Director: / Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Culling (Check Gartifying Nurse Practioner: To the best of my knowledge only one natur 29d. Date signed (Month, Day, Year) M,DD001128 Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Suite 4105 Baltimere, MD 21204 67011

State Registrar 31. Date filed (Month; Day, Year)

Physician /Medical **Examiner Funeral** Director 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or Items 23a or 28a-f show an "natural", or Items 23a or 28a-f show Me-flcal Examiner must be notified at Directo Funeral Baltimore, Maryland 21215-0036 **p** Completed the æ Pages 1 and 2 should forment of Health and Men ဥ permit. Pages 1 and 2 s
Department of Health ar
Important: if item 27 is
any injury or other trau

Physician /Medical Examiner

or Attending Physician; The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

269 Colgate Avenue Dunda 1k If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Days Hours 1 M 2 K 220-05-1708 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County MD Dundalk Baltimore 10f. Zip Code 10e. Street and Number 21222 7003 Dunbar Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes AXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Substitute Teacher 17. Father's Name (First, Middle, Last) Guiseppe Giordano 19a. Informant's Name/Relationship (Type. Print) 269 Colgate Ave. Susan McGuire (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Sacred Ht. of Jesus Cem. 4/25/201 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Immediate Cause (Final me disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate caus. Enter Unior ying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and as the burial-trai Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No the 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No ဥ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28h Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 8:00 PM eems OVISE 18 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) July 15,1918 Maryland 10d. Inside City Limits 1 Tyes 25 No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify. White 16b. Kind of Business/Industry Baltimore County Public Schools 18. Mother's Name (First, Middle, Maiden Surname) Rosaria Altomare 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 20c. Location - City or Town, State Baltimore, Maryland ^{22 Name and Address of Facility}
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed' 1 Yes 2 No Daughter's Other: $4 \square \text{ Nursing Home} \quad 5 \square \text{ Residence} \quad 6 \text{ Mother (Specify)} \quad Residence$ 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAYVIEW CIRCLE tinucane homas 32. Registrar's Signature 31. Date filed (Month, Day, Year,

State Registrar

APR 2 1 2011

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month-0025 M OYCE Dana nert APVII Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death University of Maryland Medical Center Baltimore 9. Birthplace (State or Foreign Country Maryland 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Aug. 6 Year) 1947 Days Min. 1 □ M 2 😾 F 212-50-6387 63 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Carroll Westminster 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 21157 USA 2133 Snydersburg Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, , or ! Black, White, etc 1 Never Married 2 Married δ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1
Yes 2 □ No Specify: White and Mental Hygiene. is marked other than "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Veterinary of Animals Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Elizabeth Hutchins Charles Edward Keys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2133 Snydersburg Road, Westminster Maryland 21157 permit. Page 1 and 2 st Decartment of Health a Important: If item 27 is any injury or other tra Gene Daugherty Sr.-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Apr.21, 2011 Glen Burnie Maryland Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Myocardial disease or condition 🚁 Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery Pregnant at time of death as been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has page 2 No 1 L Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, 2 No Hospital: Other: ၉ 1 Yes 1 M Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending | 24 hours after death. injury Natural 5 Pending s after death.

I Director: Aff
id in by the ful 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of 29c. License number 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore lams 32 Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elisa S. de Gutierrez 11:05 A^M Medical April 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chevy Chase Montgomery Manor Care

5. Social Security Number 8. Date of Birth (Month, Day, Ye If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🖫 F Months Days Hours Colombia **Director** 579-94-6098 Aug 17. 97 1913 Usual Residence of Decede or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 ☐ Yes 2 X No MD Montgomery Chevv Chase 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3227 Park View Rd. 20815 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married 1 X Yes 2 □ No Specify: Colombian Baltimore, Maryland 21215-0036 3 XWidowed 4 ☐ Divorced SpecifyWhite Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alejandro Suarez Maria Ramirez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luz Estella Mobin/daughter 3227 Park View Rd. Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 T Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Final Journey Crematdry 04/21/201 1 Woodbine, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 Beverly I. MO1251 MD 21029 Heckrotte, P.A. Clarksville, 23a. Part 1. Enter th / isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final disease or condition Physician/ Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Failure to Thrive 1 week Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760杀 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure 1 🗌 Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death

To the Funeral Director: A
completed filled in by the f Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) april 20,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Molly Haynos, CRNP 10110 Molecular Dr. Suite 206 Rockville, MD 20850 31. Date filed (Month, Day, Year)

State

Registrar

APR 2 1 2011

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 17 Day 2011 Year Physician/ 2210 Jane Russell Donahoe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Apr 21, 225-30-8394 Director 81 Virginia Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2X No Rockville MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20852 11402 Patapsco Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐XNo Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry عال مالا be filed with. *at Hygiene. *ar than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Administrative Assistant should be filed with and Mental Hygien 7 is marked other th Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Belle Comer 2 Garnett Russell injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) t. Page 1 and 2 sh... 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Rockford Road Silver Spring, MD 20902 Daniel M. Donahoe/son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of remetery crematory or other place)

Final Journey Crematory 04/20/2011 1 Burial 2 XCremation 3 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Going Home Cremation Service Sign were of Funeral Service Lice P.O. Box 784 MO1251 P.A. Clarksville MD 21029 Beverly L. Heckrotte, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NON smarc Pnysician cell rong disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examiner pue to for as a consequence of Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 ☐ Yes 2 ☐ No No the nucernation as a redeath.

To the Funeral Director: After this certification of the funeral director, in a filled in by the tuneral director, in a filled in by the tuneral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 1 Tes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tit 035635 KPRIL 18, WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR OLNEY 20832 32. Registrar's Sign State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death April Day 2011 Physician/ 17, 4:15 PMBarbara Fulton Davis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 12206 Riverview Road Fort Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Davs Hours July 4, Your 932 Mary Tand 220-26-7625 78 **Director** Usual Residence of Decedent permit. Page I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any jiny or other traumatic event, the Medical Examiner must he material any gine. 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 Yes 2 XNo Maryland Prince George's Fort Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20744 U.S.A. 12206 Riverview Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Business Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret K. Fulton (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12206 Riverview Rd., Fort Washington, MD 20744 Harry R. Davis (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 2 X Cremation 3 Removal from State ☐ Bugia Alexandria, VA Metropolitan Crematory 4/20/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Markwood Funeral Home 111 S. Mineral St., Keyser, Sign ture of Juneral Service Lightsee in WV 26726 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nterval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Metastatic Urothelial Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnan 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Year Month Day Pregnant at time of death ate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🗓 No 1 Yes 2 No this certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🛛 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 은 within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral is 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) X Natural 5 Pending work? 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9 D0043361 April 19, 2011

Registrar
DHMH 17 Rev 7/2009

State

2150 Pennsylvania Ave., N.W. Washington, DC 20037

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Robert Siegel, M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOSEPHINE DUCKETT-DAVIS 0525 am Month Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner land Amore N/A 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 10-4-1940 1 □ M 2 🗓 F Months Hours Min. Director NORTH CAROLINA 217-40-7335 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD. N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2501 VIOLET AVE APT 405N 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 ☐ Yes 2X No If Yes, Give imbre, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: BLACK Completed 3 😾 Widowed 4 🗆 Divorced Year or Dates traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha **FACTORY** LABORER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ ULYSSE PITTMAN BERTHA COLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 JOHN P. DUCKETT JR(SON) 2025 W. LEXINGTON ST. BALTIMORE, MARYLAND 21223 injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 4-26-2011 Other (Specify) ZION CEMETERY BALTIMORE, MARYLAND any inj 21. Signatur HIBN R22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. of Fineral Service Licensee JONATHAN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shook, or heart faild Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to for as a consequence of: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 ate has been signed by the attending page 2 should be detached for use as If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pa<u>rt II</u>. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 2 No 1 12 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 D Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation М within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionery on the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 8, 2011 10:26 PM_M Annamae K. Ellison Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death McAlmon Place Damascus Montgomery 5, Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 😾 F Months Days Hours Min 579-28-3715 Director 86 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MT Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7601 Chelton Road 20814 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No r than "natural", or iter the Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed Specify: 3 X Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 dance teacher arts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Frederick Beatrice Kraft Gertrude Scudder 1 and 2 should by of Health and Meritem 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nanette Ellison/daughter 7601 Chelton Road Bethesda, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 a Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) Signature Rolla 1d Dixector 28 Name and Address of Facilit Board 655 W. Baltimore Street 21201 Baltimore, MD nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock. rt failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) gastrointestinal hemorrhage Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury attending physician and for use as the burial-transi that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? à intestinal obstruction Completed 2 ▼ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 🗌 No Accident Investigation

Box 68760 P.O. Division of Vital Records,

To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director.

Registrar

Medical

31. Date filed (Month, Day, Year)

Suicide

4 Homicide

29a. Certifier

29b. Signati

(Check

6 Could not be

determined

McAlmon Place APR 2 1 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah Miller McAlmon Place Dema

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

City or Town, State)

20814

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

R143201

29c. License number

APRIL 20, 2011 1:55 p.m. ANNA EMERSON

				Plea	se Type o								•		•	gible.	
			For State		State	of M	larylan	-				and N	/lental Hy		20	Bresida	12808
			Registrar 1. Decedent's Name (First, Middle, Last)						uncai	rtificate of Death					N6. U	1	3, Time of Death
	Physicia Medi		Anna N	Marie E	merson									20/2	Day 1011	Year	1:55 P M
- Andrew	Examir		4a. Facility Name (ii	not institution	give street and n	umber)			4b. City	, Town, or	Location	of Death	., ., .		4c. County	y of Death	
-	 .	,	Stella 5. Social Security N	Maris	6. Sex	Ι ₇ Δ.	wa (la swa la	at tietteland		Timonium If Under 1 Year If Under 24 Hrs.			T		Ва	ltimo	
	Funeral Director		214-16-0		1 □ M 2 X	= '. A(9e (<i>III yrs. I</i> a	st birthday) Yrs.	Months		Hours	Min.	8. Date of Bi	irth 123 123	7)	9. Birth Cou	nplace (State or Foreign ntry) MD
	nd now	Ļ	Usual Residence of 10a. State	Decedent 10b. County		•	10c City	, Town or Lo	cation								10d. Inside City Limits
	farylar 3a-fsl üfied	Director	MD	Ra1	timore												1 ☐ Yes 2 No
	the Na or 2			Street and Number				Baltimore 10f. Zip Code						10g.	Citizen of	What Cou	ntry?
	h with	Funeral		Magle						212					US	SA	
36	Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Marr 3 汉 Widowed		ied Armed	Forces? s 2 2 Give	Ever in U.S No		Was Dece f Yes, spe 1 Yes				ecify Yes or No Rican, etc.)	•		ck, White,	
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Baltimore, Maryland 21215-0036	hin 72 ne. than " e Mec	Completed	Elementary/Sec		st grade complete College		5+)		kind of wo O NOT us	e retired)		st of worki	ing				
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jan	l be fill lental rked c	To			on, Sr.								Martir		n Surnam	e)	
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-	h si i n Medical		Immediate Cause (disease or condition resulting in death)					EMENT]	Α							- 1	Onset and Death
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 1							23d. Date of delivery Month Day Year							
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ta	nysician: The nis certificate director, pag		25. Was case referre examiner?		Hospital:	26. Place of Death (Check only one)											
Ž	r this eral dir	일:	1 L Yes 2 1 27. Manner of Death	No No	28a. Dat			R/Outpatier	t 3 DOA Other: 4 Nursing Home 5 Residence 6 NO Other (Sp. 28c. Injury at 28d. Describe how injury occurred						HOSPICE		
on o	anding bath. Tr. Afte	Certificate:	1 X Natural 2 Accident	5 Pendin Investig	ation	(Month, Day, Year) injury			work? M			zod. Describe now injury occurred					
Division of Vital Records,	I or Attending after death. I Director. After d in by the fune		3 ∐ Suicide 4 ☐ Homicide		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			- 1	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2		Physician: To the caminer: On the b	asis of e	xamination	and/or invest	igation, in	my opinior	i, death o	ccurred at	the time, date a	and plac	e, and due	e to the ca	use(s) and manner state
	To the within 2 To the comple	ı — r	only one) 3 29b. Signature and t		Nurse Practione	r: Io the	Dest or my	knowleage, a		License		and place	e, and due to th		e(s) and ma late signed		
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2			30. Name and addre		ho completed ca					,							
	Stat	e	JACKIE 31. Date filed (Month	n, Day, Year)	32.		DULA ar's Signatu	VEY VA	LLEY	RD.	TIM	ONIU	M, MD 2	2109	3		
	Registra			APR 2	1 2011	Best	wa	A. 1	bar								

DHMH 17 Rev 7/2009

11-02928 Jodie Ann Elms		of Maryland / Departme	ole Ink. Ensure All Copi ont of Health and Mental H te of Death	lygiene	2011	12809			
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle, Last Jodie A.		to or bodin	2. Date of Death Month Da April 17, 201	v Year	3. Time of Death 2328 hrs			
	4a. Facility Name (if not institution, give 14719 Old Hanover Road	street and number)	4b. City, Town, or Location of Dea Upperco		4c. County of Death Baltimore Cou	nty			
Funeral Director	5. Social Security Number 6. Se. 219-74-3936		day) If Under 1 Year If Under 24Hi Months Days Hours Mi Yrs.		MM/DD/YYYY) 9. Birth Foreign Cou				
nd haw any ce.	10a. State 10b. County MD Baltin	10c. City, Town o	rLocation			10d. Inside City Limits 1 Yes 2 No			
death with the Maryland or items 23s or 28s-f show must be notified at once.	10e. Street and Number	nover Road	10f. Zip Code 21155	. Zip Code 10g. Citizen of What C					
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puerl Yes 2 No specify:		14. Race - Americ White, etc.	can Indian, Black, White			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after neart of Health and Mental Hygiene. ant: If item 27 is marked rither than "natural", or other traumatic event, the Medical Examiner To Be Completed by I	15. Decedent's Education (Specify on Elementary/Secondary (0-12)		ecedent's Usual Occupation (Give kind of uring most of working life, DO NOT use re		b. Kind of Business/Ir	***************************************			
21215-0036 uld be filed within 7 Mental Hygiene. marked nither than cevent, the Medica	12 17. Father's Name (First, Middle, Last)	Z1mg		ne (First, Middle, Maid		1			
MD 2121, nd 2 should be fil. alth and Mental F m 27 is marked aumatic event, i	Richard Elms Elizabeth Ann McDowel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Jessica Weitzman Daughter 14719 Old Hanover Road Upperco, Mary								
Baltimore, MC oemit. Pages I and 2 st Oepartment of Health an important: If item 27 i injury or other trauma	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State cremator	Disposition (Name of cemetery, y or other place) 1 Cremation 4	Date 20 /20/11	Oc. Location - City or Hampste				
	21. Signature of Funeral Service Licens	m Jenkons	22. Name and Address of Facility 1 ELINE FUNERAL HOME enter the mode of dying, such as cardiac		stown, Mar	oad y1and 21136 Approximate Interval			
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iner	eause: Entire Underlying Cause	Due to (or as a consequence of):			, i				
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Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial-ledical Certification: To Be Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ✔ Unknown	1 Live birth 2 [4 Pregnant at time of death 5 [Fetal death 3 Ectopic pregr Other (Specify)			ay Year			
i, P.O. B ires that the d signed by the I be detached d by Phy	Part II. Other significant conditions	Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to total Table 2 Inc. Inc. Inc. Inc. Inc. Inc. Inc. Inc.							
Records, The law requires ficate has been signage 2 should be Completed				24a. Was an eutopsy performed 1 ✓ Yes 2	prior to co	opsy findings available ompletion of cause of			
Vital Rec ysician: The b his certificate b director, page o Be Corr	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 ER/Out	26.Place of Death (Check		idence 6 Other				
on of Vi ending Physi ath. r: After this he funeral dir tion: To	1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	me of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how		Scotte			
Division or Attending in the Hospital or Attending in within 24 hours after death. The the Funeral Director: After completely filled in by the funeral ledical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Homicide Homicide 1 Accident Investigation 5 Suicide 6 Could not be determined Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
To the Hoswithin 24 ho To the Fun completely	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 30. Name and address of person who c	completed cause of death (Infim 23c)	29c. License number O.C.M.E.		pril 18, 2011	un, ∪ay, Year)			
-0	Zabiullah Ali, M.D. Assis	tant Medical Examiner 111	Penn Street, Baltimore, MD 2	1201					
State Registrar	31. Date filed (Month, Day Year) APR 21 2011	32 Registrar's Signature	bare						
DHMH 17 Rev 1/2001		ORIG	GINAL			OCME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death April 16, Day 2011 Year Physician/ 3:10 P M Paul E. Forney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville Summit Park Nursing Home 8. Date of Birth
0ct. T5, 1925 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 ☐XM 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Hours Maryland 85 219-18-1201 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director Lansdowne 1 Yes 2X No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 21227 209 5th Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Retail Manager Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Mary Joseph Walsh မ should be Walter Forney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 209 5th Avenue, Lansdowne, MD 21227 Mildred Forney - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Surial 2 Cremation 3 Removal from State Baltimore, MD New Cathedral Cemetery 4-20-2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. Funeral Service Licensee 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death DEMENTIA Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): SENILIT Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last ı physician a s the burial⁴ Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTENT CO ROW ART Records, 1 Yes 2 No 3 Probably 4 Unknown EXPOSURE Were autopsy findings available prior to completion of cause of ASBESTOS 24a. Was an autopsv page performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0056948 ATTENDING APRIL 19 6x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 204 BATIMORE 10 21229 3455 WILICENS NE TANSINDA TANO

Registrar

State

31. Date filed (Month Day Year) APR 2 1 2011

Box 68760

P.O.

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Physician/ 12:50P M Elsie E. French 2011 April 4. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Friend's Nursing Home Sandy Spring Montgomery Social Security Number Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. Nov 28, 1913 Connecticut 97 **Director** 079-38-1500 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 ☐ Yes 2 X No MD Montgomery Sandy Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20860 USA 17340 Quaker Lane #226 rral", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or raumatic event, the Medical Examir Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Registered Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ./101c,
rit. Page 1 and 2 shc.
rant of Health and Mc.
'tem 27 is marked c. ည George R. Edmond Daisy Lord 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy F. Traub/daughter 6744 Mahogany Drive Galena, OH 43021 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti Baltimore, 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematdry 04/21/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 N/E Clarksville MD 21029 MO1251 Beverly L. Heckrotte, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure to Thrive years Medical disease or condition resulting in death) Due to (or as a consequence of Examiner Dementia years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events burial-transi Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Osteoarthritis, Osteoporosis, Weight loss, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of Malnutrition, Cancer of Hard Palate 24a. Was an autopsy page performed?

1 Yes 2 No death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be Hospital: Other: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) မ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat**∕ir**e and **∔itl**e of certifie 29c. License number 29d. Date signed (Month, Day, Year) HWan D53367 April 19, 2011 WV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Ave Suite 117 Silver Spring, MD 20902 Shyamsundar Rajan, M.D.

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's ignatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 15,2011 3:15 P M Louise W. Frost Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Sandy Spring Friends Nursing Home Year If Under 24 Hrs. If Under 1 8. Date of Birth 9, Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral Davs Hours Month, Day, Jun 8, Montana 1 🗆 M 2 💢 F Director 1916 501-50-1985 94 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Sandy Spring MD Montgomery 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 20860 UŠA Funeral 17340 Quaker Lane death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 hours after 1 ☐ Yes 2X No Specify: Specify: White "natural", Completed 3 XWidowed 4 ☐ Divorced Year or Dates. nit. Page 1 and 2 should be filed within 72 hours natment of Health and Mental Hygiene. ordant: If item 27 is marked other than "natur injury or other traumatic event, the Medical. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. **7 is marked other than "**n Elementary/Seconday (0-12) College (1-4 or 5+) Journalist Own Business 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Adelia Nelson John Oscar Wold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3420 Chatham Road Adelphi, MD 20783 19a. Informant's Name/Relationship (Type, Print) Frances Gulick/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Final Journey Crematory 04/22/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig Going Home Cremation Service P.O. Box 784 Clarksville, MD 21029 Beverly L. Heckrotte, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ a Atherosclerotic Cardiovascular Disease years disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of If any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown has been signed by e 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia, Failure to Thrive, Hyperlipidemia, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an Congestive Heart Failure autopsy page performed? Physician: The certificate I 1 🗌 Yes 2 🗌 No Within 24 hours after death.

To the Funeral Director After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 XNo 1 Tyes ျှ 1 Inpatient 2 I ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month. Day, Year) 04/19/2011 as D53367

Registrar
DHMH 17 Rev 7/2009

State

Shyamsundar Rajan, M.D. 9801 Georgia Ave. Suite 117 Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Jean Fleig 12:30A M A Pril 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 9 St. Timothys Lane Catonsville Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 F Hours (Month, Day, 70 216-36-1995 Maryland **Director** Jan. Usual Residence of Decedent 28a-f show 10b. County ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 United States 9 St. Timothys Lane I Hygiene.
Other than "natural", or items of yent, the Medical Examiner mu within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 A Married β Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify. White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Aid Medical unknown event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nt of Health and Mental H t: If item 27 is marked ot or other traumatic even မ Edward John Seicke Mildred Easton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fleig Timothys Ln., Catonsville, Maryland 21228 Bruce Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) ō Department Important: If any injury or Metro Crematory Inc. 04/21/2011 |Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final End-Stage (OPD Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): nding physician and se as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 this certificate has been signed by the attending praid director, page 2 should be detached for use as IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\overline{P}\) Residence 6 \(\sum \) Other (Specify) 2 🗹 No Hospital 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ns Rajapahre M.D DOUS7465 4/21/11

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

N.S. Rajapakse, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

5mith AV

5-703

Baltimore MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 7,8 per fh g914 4-25-11 vt
State of Manyand / Department of Health and Mental Hygiene
Amend item#12,19a,perff,G915,5/4/2011,WS

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Vincent Foster David April 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Cente Towson Date of Birth 1934 (Month, Day, Year) 9C 29, 1924 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1**x**□ M 2 □ F Hours Min. 215-34-1643 MaryTand Director Usual Residence of Decedent 10c. City, Town or Location ms 23a or 28a-f shorms must be notified at 10a. State 10d. Inside City Limits Funeral Director Lutherville Baltimore 1 ☐ Yes 2X☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 21093 143 Othoridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Nas Deceuc... Armed Forces? 1 X Yes 2 Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give WW II Year or Dates. Vietnam 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Construction Equip. Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kurts Vincent Foster Lee Clarence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) per it. Page 1 and 2 sh Decartment of Health ar Important: If item 27 is any injury or other trau 143 Othoridge Rd., Lutherville, MD 21093 Jeri Lynn Foster-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4/22/11 Timonium, MD Dulaney Valley 4 ☐ Donation 5 ☒ Other (Specify) Entombrent 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Emborism Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Duc to (or as a consequence of,: or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ONSTRUCTIVE pulmanary 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After it 1 Natural 5 \square Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Cynthia Small MO 29c. License number 29d. Date signed (Month, Day, Year) 00057347 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYNTHIA SOCIANO MD 6701 N-CHARICS ST BAITIMORE MD 21204 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 14^{pay} 201 Tear Nelson Donald Garber 3:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Year) 1935 1 X M 2 - F Hours 578-44-9935 Vrs Washington DC Director Usual Residence of Decedent show er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Laurel Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8239 Slippery Rock Way 20723 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1053. 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Phillip Garber Yetta Banner 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8239 Slippery Rock Way Laurel, MD 20723 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jill M. Owen/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State Final Journey Crematory 04/18/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Atherosclerotic Cardiovascular Disease disease or condition vears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or iinjury that initiated events physician and is the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 d guipt se as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Abdominal Aortic Aneurysm 1 ☐ Yes 2 承No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Iliac Artery Stenosis, Hypertension, Coronary Artery 24a. Was an autopsy performed? Yes 2 No death? Disease, LT Gangrenous Foot, Ischemic Colitis 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 XNo Other: ပ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending after death. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 Gertifying Nurse Fractioner: To the best of my knowledge identiof the Store 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 15, 2011 D53367 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shyamsundar Rajan M.D. 9801 Georgia Ave. Suite 117 Solver Spring, MD 20902

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:55 PM tra V dos _ewis 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b/ City, Town, or Location of Death Examiner The Johns Hopkins Hospital Baltimore City 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea August 26, 5. Social Security Number 7. Age (In yrs. last birthday) Year. **Funeral** Hours 1**X** M 2 □ F 1944 215-42-8529 66 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d, Inside City Limits 10c. City, Town or Location 10b. County 28a-f show 1 ☐ Yes 2X No MIddle River Director Maryland Baltimore Examiner must be notified 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ъ USA 21220 13106 Patuxent Road Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐ Yes 2 ☐XNo ō White If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Government Master Mechanic the 10 years other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leona Lacey Lewis Gaydos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trat once. 13106 Patuxent Road, Middle River, Maryland 21220 Elizabeth M. Gaydos 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 23, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) 2011 Bayview Crematory nature of Funeral Service Livens 22. Name and Address of Facility Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Parf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mulocardia disease or condition resulting in death) /Medical Du to (or as a consequence of) **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of or Attending Physician; The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) **Director**; 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide hours after the Hospital within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification 29c. License number RES-000 April 19 , 2011

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

21215-0036

Baltimore, Maryland

Box 68760.

P.O.

of Vital Records,

Division

600 North Wolfe St, Baltimore, MD, 21287

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4 Physician/ BREK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u>Catonsville</u> <u>Baltimore</u> <u> Charlestown Care Center</u> 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Dec 7, 1918 1 □ M 2 Months Hours Min Maryland 213-09-6088 **Director** 92 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at filed within 72 hours after death with the Maryland Director 28a-f Catonsville Maryland Baltimore 1 Yes 2 XNo 10e. Street and Number ŏ 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 21228 USA 709 Maiden Choice Lane RGS 416 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ō ģ 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail of Health and Mental Hygi item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve ပ Katherine Elizabeth Kroner Louis Charles Uebel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3944 River Road Sneads Ferry, NC 28460 Susan Tuman, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State 04-20-2011 Metro Crematory INC Baltimore, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society Of Maryland IN 299 Frederick Road, Baltimore MD 21228 neral Service Licensee Patrik Fleming Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ tuntington's disease or condition resulting in death) Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been sinced to the continued to been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregn; 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor 5 Other (specify) Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi-29c. License number 29d. Date signed (Month, Day, Year) 10 D003929 2011 30. Name and address of pers n who completed cause of death (Item 23a) (Type, Print) Maiden Choice Ln., Dr. Michael/Ro. 715 Catonsville, Maryland 21228 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PHILIP E. **GIANNINO** APRIL 19 2011 5:50 Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CATERED LIVING OF COCKEYSVILLE COCKEYSVILLE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 2 - 4 - 1928 9. Birthplace (State or Foreign Funeral **1**X M 2 □ F Days 216-28-7203 83 Yrs. MARYLAND **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director BALTIMORE MD ROSEDALE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8015 CARADOC DRIVE 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Year or Dates 950 – 56 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc <u>چ</u> 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 XNo Specify. tem 27 is marked other than "natural", other traumatic event, the Medical Exa Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) 12 5+ ACCOUNTANT SELF Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SEBASTIAN GIANNINO JOSEPHINE GIGLIO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i PATRICIA DEMSKI/SISTER 13828 MANOR GLEN ROAD BALDWIN, MD 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1.2
Department of I Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) GARDENS OF FAITH 4-26-2011 BALTIMORE, 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 2 1 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 1 Yes Other: 2 No 2 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) HIS Seed Living 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined hours within 24 hours
To the Funeral Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

Registrar

State

- 18Gg

ISIa CK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

6701

1)0061199

St Svite

Touson

4105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 17 Margaret Gerunsio 10:39 8 2011 MAIL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Season Hospice at Northwest Hospital Randallstown 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 11<u>/29/1920</u> 1 M 2 F Hours Min. 016-12-0163 90 Director Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "naturo" any injury or other traumatic event. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗓 No MD Anne Arundel Co. Linthicum Heights 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21090 300 Jerlyn Avenue United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Completed 3X Widowed 4 □ Divorced Specify: White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Dance Instructor Dance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Elsie Renz Ignatius Moog 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 Ms. Annette M. Gervasio/Daughter 6397 Centennial Circle Glen Burnie, MD 20a. Method of Disposition
1
Burial 2
Cremation 3
Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 04/20/2011 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licer M01121 2nd Ave SW; Glen Burnie, MD 21061 Services PA: 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final - End-Stage Dementia Ph. sici an disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tor: After this certificate has been signed the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: T within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) MSRajapameM.D D0057465 4/18/11

State Registra

10 V

BIVD

Gipn Burnie,

MD. 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS POUNTION BIVE

31. Date filed (Month; Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland 7 Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No. Registrar Decedent's Name (First, Middle Last)
Clarence Jame Green II 2. Date of Death 3. Time of Death Physician/ Month Da April 4, 2011 1807 hrs Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Raltimore Johns Hopkins Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex If Under 1 Year If Under 24Hrs. **Funeral** Foreign unk Months Days Hours Director Country) 216-92-7016 1× M 2 F Yrs 46 6-21-64 MD Usual Residence of Decedent 10d. Inside City Limits UNK 10c, City, Town or Location 10a. State 1171 10b. County -unk unk Yes 2 No N/A Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g, Citizen of What Country? 10e. Street and Number unk 10f. Zip Code unk 8937 Waltham Woods Rd. 21234 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. unk 1 X Never Married 2 Married 2 X No 1 Yes **Black** 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: 2 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed th and Mental Hygiene.

a 27 is marked other than "numatic event, the Medical E Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th grade unemployed disability 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk umatic event, Be Clarence Green **Annie Sutton** 19a. Informant's Name/Relationship (Type, Print) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Dorothy Moore (Aunt) 614 Alton St. Elizabeth City, NC. 27909 ont of Health a at: If item 27 20a. Method of Disposition unk 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Dateunk 1 Burial 2 X Cremation 3 Removal from State Department o Important: 1 injury or oth 4-18-11 on-site crematory Baltimore, Md. Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 27056644656668600 Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Medical Between Onset and failure. List only one cause on each line Death Complications of Cocaine Toxicity Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Caus. (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last d and 5,7-10c,10e-20c per fh g914 4-21-11 vt 23a,27,28a-f per me g915 5-9-11 vt g physician a X UNPENDED X AMENDED Physician/Media Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death 1 Live birth 3 Ectopic pregnancy Month Day Year use as t past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an has been prior to completion of cause of autopsy performed? death? page ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) 25 Was case referred to medical Be examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other 1 Yes this 2 No 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28d. Describe how injury occurred After 27. Manner of Death 28c. Injury at Work? Certification: ■ Natural 1 1 Yes 2 X No after death.

Director: A in by the fi 5 Pending fd 11:15pm fd 4-1-11 unknown 2 _ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be or Town, State) 1600 blk. Edison Hgwy within 24 hours at To the Funeral I filled determined (Specify) Baltimore, found unresponsive on street Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and due to the course of the course o completely Cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 5, 2011 Delthell. anull 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Leroy Harrison 18 2011 9:50 A April Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Baltimore Co. Essex 10 Woody Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) av 3,194 Days Country 1 **∑** M 2 □ F Months Hours 218-36-0574 **Director** Yrs Maryland 69 Mav Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits 10c. City, Town or Location must be notified at Director 1 ☐ Yes 2 🌡 No Essex Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 10 Woody Road 21221 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō, 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Yes 2X No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meonee. Elementary/Seconday (0-12) College (1-4 or 5+) Brewery Machinist 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Catherine Ayers Roland Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21221 10 Woody Road Essex, Maryland Mrs. Gloria Harrison (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Bel Air Mem. Gdns.Cem. 4/22/2011 Bel Air, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death Priysician/ mina disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause (Disease or injury turminediate Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ Unknowr been signed by the sahould be detached it q | Unknown Part II<u>.</u> **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an cate has page 2 s autopsy After this certificate 1 🗆 Yes 2 Yes 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred iniurv 1 Natural 5 Pending 2 🗌 No ☐ Accident Investigation after death Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type Baltimore

State Registrar Day, \

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -Month **Physician** John April Hendrichs 14 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center N/A **Baltimore** Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday **Funeral** 1 🖳 M 2 🗆 F 87 Director 217-12-8590 Maryland 9,1923 Oct. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TXNo Director Dunda1k MD Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 3405 Yorkway United States 21222 Funera Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 2 Specify: WWII 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 1 Year Steel Industry Foreman 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle P. Wolf Charles Frederick Hendrichs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1322 Terryway Fallston, Maryland 21047 Mr. John L. Hendrichs (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4/19/2011 4 Donation 5 M Other (Specify) Entombment Sacred Ht. of Jesus Cem. Dundalk, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Funeral Service Licensee 21. Signature 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASCVO Physician long standing disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? for Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \sum Nursing Home 2 R/Outpatient 1 Inpatient 3 DOA 5 Residence ၉ 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 Tes 2 🗌 No 2 Accident death. after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral D Hospital 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Funer completely fi Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

let 1

State Registrar 11 A V J M A ,
31. Date filed (Month, Day, Year)

APR 2 1 2011

32. Registrar's Signature

ORIGINAL

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

Apr. 114, 2011

D-0061115

DHMH 17 Rev 1/2001

11-02934

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 12823

Jarrei Hoistein	1- For State	partment of Health and Meni ertificate of Death	Reg. No.	I I fall for \					
Physician Medical Examine		Holstein	2. Date of Death Month Day Year April 18, 2011	3. Time of Death 0350 hrs					
incultar Examine	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of							
Funeral	Johns Hopkins Bayview Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs	Baltimore s. last birthday) If Under 1 Year If Under	N/A r 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. E	Birthplace (State or					
Director	213-80-9620 1 M 2 F 47 Usual Residence of Decedent	Yrs. Months Days Hours	Fore	eign Country) MD					
W any	10a. State 10b. County 10c. City, Town or Location								
Aaryland 28a-f show 1 at once	MD Baltimore	Dundalk 10f. Zip Code	10g. Citizen of What Co	1 Yes 2 No					
n the Maryland Sa or 28a-f sh officed at one	7831 Fairgreen Road	21222	United St						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Furneral Director	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Yeer	If Yes, specify Cuban, Mexican,	Puerto Rican, etc.) White, etc.	erican Indian, Black,					
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5-0036 ed within 72 hour sygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years	during most of working life. DO NOT		nates, Ltd.					
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2121 nould be find Mental I is marked tic event,	Stanley Holstein 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Num	herine Plaggenberg ber or Rural Route Number, City or Town, Sta	te, Zip Code)					
MD and 2 should be safely and 27 is summer in	Mrs. Starr A. Holstein(Wife)	7831 Fairgreen Ro							
Ore, ges 1 ar it of Heg i: If ite	1 X Burial 2 Cremation 3 Removal from State	p. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery	Date 20c. Location - City of 4/22/2011 Baltimo:	re, Maryland					
Baltimore, Defarine Pages 1 at Department of He Important: If ite	4 Donation 5 Other Specify: 21. Signature of Funeral ervice Licen:		ral Home of Dundalk,						
Physician	23a. Part I. Enter the disease, or complications that caused the dea	7922 Wise Ave.	Dundalk, Maryland :	21222 Approximate Interval					
Wedical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease a. Myocarditis			Between Onset and Death					
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ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
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on of Vital Records, P.O. Box 68760, ending Physician: The law requires that the death certificate be executed ath. or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transition: To Be Completed by Physician/Medical Extransition:	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
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tal Rectin: The certificate ector, page	25. Was case referred to medical	26.Place of Death (1 Yes 2 No 1 V	res 2 No					
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Divisi	2 Accident Investigation 3 Suicide 6 Could not be determined	home, farm, street, factory, office building, etc	28f. Location (Street and Number or F or Town, State)	tural Route Number, City					
Di To the Hospital within 24 hours a Yo the Funeral 1 completely filled	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier	29c. License number	29d. Date signed (M	onth, Day, Year)					
	Ly hi,	O.C.M.E.	April 19, 2011						
6		1 Penn Street, Baltimore, MD 2120	01						
State Registra		ature							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 Physician/ March 27, 7:30 AM M Mark C. Harrison Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 2535 Thomas Run Road Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Oct 1, 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Min. 1 😿 M 2 🗆 F Hours 192<u>3</u> **Director** Yrs 194-16-0667 87 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Bel Air 1 Tes 2 T No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2535 Thomas Run Road 21015 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed 3 Widowed 4 Divorced white 43-46 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) self employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mark C. Harrison Melisa Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Harrison/spouse 2535 Thomas Run Road Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Signat of Euneral Service Licen ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director **Baltimore** MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Due to (or at a consequence ory. Exami Cause (Disease or linjury that initiated events and -tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) ate has been signed by the atte page 2 should be detached for in the past 12 months? Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical fureral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 🔲 Yes 24 hours after death. Funeral Director: Ai 2 🗌 No completed filled in by the t Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

HARRISON

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	f Maryland		rtment of H			giene' i l Reg. No.	14040
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			5. Social Security Number	6. Sex	7. Age (In yrs. I	,	If Under 1 Year	If Under 24 Hrs	8. Date of Birt		9 Birtholace (State or Foreign
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ğ	permit. Pages Department of I Important: If It eny injury or of		21. Signature of Funeral Service ROTI	ald Sylve	de Dire	ctor				W. Balti	more Street
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Division of	g Physi er this c	- :-	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o	f 28c. Injui			how injury occurre	
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			xuu	THE	70/14		Do	03071	7	04/13	1/20/1
		-	30. Name and address of person	n who completed cal	use of death (Item	23a) (Type,	Print) Alic	ig A.C	001, mD		
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DHMH 17 Rev 1/2001

			For State	State of M		/ Depa	artment of	Health an	d Mental Hy		_	Jible.	1000	
			Registrar 1. Decedent's Name (First, Middle, L.	ast)			tificate of	Death	2. Date of De	Reg. I	No.		3. Time of Dea	th-
	Physicia Medi		ACEICE	A	Hil	P			Month (Day 7	23011	1/1	М
4	Examir		4a. Facility Name (if not institution, gi				4b. City, Town,	or Location of De	eath		1c. County			
	Funeral		6409 Wood Point 5. Social Security Number 6.		je (In yrs. last i	hirthday)	Glenn If Under 1 Year		Hrs. 8. Date of Bir	_	Princ		orge's	
	Director			1 □ M 2 Ø F	84	Yrs.	Months Days		lin. (Month, Da June 8	y, Year	926	Sout	olace (State or Fo. try) h Caroli	na.
	Maryland 28a-f show otified at	tor	10a. State 10b. County		10c. City, To	own or Loc	ation		-			1	0d. Inside City Li	mits
	Mary 28a-i	Director		George's	Glen	n Dal							1 💢 Yes 2	□No
	s 23a or nust be r	Funeral I	10e. Street and Number 6409 Wood Point I	rive			10f. Zip Code 20769				Citizen of V	What Cour	ntry?	
	r item iner n	Fur	11. Marital Status	12. Was Decedent E Armed Forces? 1 \(\subseteq \text{ Yes} \(2 \subseteq \text{ A}	Ever in U.S.	13. W	as Decedent of I	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)			e - Americ		
21215-0036	s after ral", o Exam	Completed by	1 ☐ Never Married 2 ☐ Married 3 1 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	No	- 1	☐ Yes 2 🗓 No				Specify:			
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d 2	led wil Hygie other ent, th	Be	17. Father's Name (First, Middle, Last,	3		Libr	arian	18 Mother's I	Name (First, Middle,				Congress	
/lan	d be fi Vental arked atic ev	욘	Pinkney Alexander					1	Williams	iviaiue	n Surname	7)		
, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ralph Jackson (Ne	** '					Rural Route Numbe Glenn Da	-			Code)	
Baltimore,	pe 1 ar t of He If item or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [Removal from State	20b. Place ceme		ition (Name of atory or other pla	ce)	Date	20c.	Location -	City or To	wn, State	
Itim.	iit. Pag artmen ortant: njury		4 Donation 5 Other (Spec	ify)	Map1	ewood		4-2	21-2011		eensb		-	
Ba	Department of the position of		21. Signature of Juneral Service Licer	Mari					ne ., Greensl		o, NC	274	01	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	plications that caused one cause on each line	the death. De	o not enter		~ .	1	est,			Approximate Interval Between	1
	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a Due to (or as a	End	500	05/	Jensen	dia			_	Onset and Death	
most 1	Examiner			Due to (or as a	a consequenc	e oi):	*)	
(T	. #	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying	Due to (or as a	a consequenc	e of):								
ND :	sician and burial-transit	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last	c Due to (or as a	3 consequence	e off:						\perp		_
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876	ng phy as the	Medi	IF FEMALE:	- d					_	-				
ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate he executes	attending physics of the tent.	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 1 Pregnant at	2 Fetal dea		Ectopic pregnand Other (specify)	су		1	23d. Date	e of delive	ery Day Year	
. B	been signed by the should be detached	hysi	1 Yes 2 No 9 Unknown	9 Unknown	time of deati	, ,,,,	Other (specify) _				,,,,,		,	
P.O.	gned b	by P	Part II. Other significant conditions	ontributing to death bu	ut not resultin	g in the und	derlying cause gi	ven in Part I.	23e. Did to	bacco	use contri	bute to th	e cause of death?	1
rds	een si	eted		-					_ 1 🗆 \	es 2	2 □ No	3 🗌 Prob	ably 4 Unkn	own
eco	has b	du							24a. Was a autop perfor	sy	l p	Vere autop rior to cor eath?	sy findings availa npletion of cause	ble of
<u> </u>	tificate or, pa		25. Was case referred to medical				26 DI	lace of Death (CI	1 🗆 Yes	2		Yes	2 🗌 No	
Vita	lis cer direct	To Be	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 ER/0	Outpatient	Oth	er:	Home 5 Resid	ence	6 □ Othe	r (Specify)		
of of	Viter th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injur (Month, Day,	y 28b Year)	. Time of injury	28c. Injur work	y at	28d. Describe ho					
Sior	death	Certificate:	2 Accident Investigatio 3 ☐ Suicide 6 ☐ Could not b	e Dlage of Initia	n. Athema	form street	M 1 □	Yes 2 No	0001 11 10					
Division of Vital Records,	i Dia	Cer	4 ☐ Homicide determined	building, etc.	(Specify)	iami, streei	i, lactory, office		28f. Location (Si City or Town	treet al n, State	nd Numbei e)	r or Rural i	Route Number,	
D	24 hou Funer eted fill	Medical	(Uneck 2 L. Medical Exam	sician: To the best of r iner: On the basis of ex	amination and	or investigation	ation, in my opinio	on, death occurre	d at the time, date ar	nd place	e and due	to the cau	se(s) and manner s	stated.
To the	Within To the compl		only one) 3 L Certifying Nur 29b. Signature and title of certifier	se Practione to the b	est of my kno	wledge, dea	ath occurred at the 29c. License				(s) and mar ate signed			
			> Thul	Te TO	The con		0	V1438		A	mi	11	9 2011	1
-	3		304 Name and address of person who	empleted cause of de	ath (Item 23a)	Type, Prin	INSEH	w , A	NAPOUS	114	214	(1)		
	State Registra	_	APR 21 2011	32. Registrer	's Signature	مدا	, - , -	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Month JAMES R. HINKLEMAN APRIL 17,2011 9:50 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MANOR CARE NURSING FACILITY DULANEY BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Min. 215-14-4705 Hours 87 7-3-1923 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits MD BALTIMORE ROSEDALE 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6404 KENWOOD AVENUE 21237 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGER WAREHOUSE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JULIUS HINKLEMAN ELIZABETH Ε. O' DONNEL) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL J. HINKLEMAN/SON 6404 KENWOOD AVE ROSEDALE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LORRAINE PARK CEM 4-21-2011 BALTIMORE, MD 21. Signature of Funeral Services icensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237 ROSEDALE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 80state CUNCLY Due to (or as a consequence of): mellity Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence on) Hyportension

Due to (or as a consequence of): Accident exebroroscular IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed; 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man or of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 □ Yes 2 □ No 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

21206

Physician /Medical Examiner Examine

and

certificate

death after death Director:

within 24 hours after des To the Funeral Directo completely filled in by th

director,

funeral

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Physician

/Medical

Examiner

Funeral

Director

28a-f show

"natural", or items 23a or 28a-f shovedical Examiner must be notified at

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Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic events.

Baltimore, Maryland 21215-0036

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Director

Funeral

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attending physician for use as the buria

Physician/Medical

Completed by

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Certification: To

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

Jayant

31. Date filed (Month, Day,

29b. Signature and title of certifier

P.0. Records, Vital Physician: Division or Hospital or Attending

State Registrar

DHMH 17 Rev 1/2001

6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ma

Gimara



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ds)er Drin, Towson,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Harrell April 9:52A James 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death

Baltimore 4b. City, Town, or Location of Death Examiner Gildhrist Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min. Country) SC 217.20.27/2 (Month, Day, Year) 81 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Baltimore 1 Yes 2 ☐ No ö 10e. Street and Number 10g. Citizen of What Country? 3102 Walbrook Avenue Funeral 23a 21216 filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Medical Examiner Armed Forces?

1 Xyes 2 □ No If Yes, Give 5 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday,(0-12) College (1-4 or 5+) traumatic event, the Bethlehan Steele 12th grade Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျ Wiley Harrell Martha Mavis and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau once. Harrell 3102 Walbrook Adente Baltimone MD 21216)aisvi 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
YOUTUS (emetery) 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 12011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Greene Fundral Service 22. Name and Address of Facility Vallahn Randall stown MD 21133 8728 Liberty Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause Einal Onset and Death Physician/ disease or condition resulting in death) METASTATIC NUNSMALL CALL LUNG CHUCOP Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Day to (or as a nonsequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the aid be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, ATRIALFIBRILLATION 1 Yes 2 No 3 Probably 4 onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has blirector, page 2 s autopsy performed?

Yes 2 No death? Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2'- No ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 other (Specify) Liter death.

**I Director; After th.

**I in by the furmant in th 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after
To the Funeral Direcompleted filled in b Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 046366 erson who completed cause of death (Item 23a) (Type, Print) NOPTH CHARLOC

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_			State Amend Item 23	State of Marylar Sa per dr., g	nd / Depa 916, 06 <i>Cer</i>	rtment o /16/201 titicate o	f Health 1 dhb f Death	and Me	ntal Hyg	iene _{eg. N} 2 0 1 1	12829
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Edward R. Hanna						Date of Deat Month pril 1	h 18,2011 Year	3:50° Death -5:00 P. M
	Examir		4a. Facility Name (if not institution, give stree 4009 Wilke Avenue	et and number)		4b. City, Town	n, or Location			4c. County of Dea	ath
Ī	Funeral Director		5. Social Security Number 214-12-8473 6. Sex	7. Age (In yrs.	last birthday) 90 Yrs.	If Under 1 Ye Months Da		Min. A	Date of Birth (Month, Pay, pril 2		rthplace (State or Foreign ountry 1and
	ind show at	or	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Loc						10d. Inside City Limits
	Maryla 28a-f	Director	Md.		Balti						1X Yes 2 □ No
	with the Maryland s 23a or 28a-f sho ust be notified at	Funeral D	10e. Street and Number 4009 Wilke Avneue			10f. Zip Coo	206		1	10g. Citizen of What C USA	ountry?
5pm	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumattic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married	Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	l II	Vas Decedent of Yes, specify C	uban, Mexica	an, Puerto Rica	Yes or No- an, etc.)	14. Race - Am Black, Whi Specify:	erican Indian, te, etc. White
1215-0	within 72 hougiene.	Completed	15. Decedent's Educat (Specify only highest grade control of the secondary (0-12) 9th		(Give F	lent's Usual Ockind of work do O NOT use retii Craft E	ne during ma red)			16b. Kind of Business Martin's	s Industry
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√ Narv	2 should lith and Me 27 is marl		19a. Informant's Name/Relationship (Type, F Nancy Stanley	Print) DTR.	19b. Mailin	gAddress Str 9 Wilk				Gity or Zawa, Glate, Z	ip Code)
APRIL altimore.	Page 1 and nent of Hea ant: If item any or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Place of Dispo cemetery, cren t Holy	natory or other	place)	Date -25-20		20c. Location - City of Balto. Md.	
A Balti	permit. I Departm Importa any inju		21. Signature of Funeral Solvice Licensee			. Name and Ac	Idress of Faci	lity S r Road		ek Funeral tingham,,M	
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HW/ Box	law requires that the death certifications been signed by the attending to 2 should be detached for use as	Physician/M	in the past 12 months?	If yes, outcome of pregn 1 Live Birth 2 Fe' 4 Pregnant at time of 9 Unknown	tal death 3 📙	Ectopic pregi Other (specif)				23d. Date of d Month	elivery Day Year
) - S	ires that the signed by	by	Part II. Other significant conditions contrib	outing to death but not re	sulting in the u	nderlying caus	e given in Pa	t I.	23e. Did tot	1	to the cause of death?
SWARD al Records	To the Hospital or Attending Physician: The law requires that the death certification after death. To the Funeral Director: After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as	Completed							24a. Was a autops perfori 1 Yes	sy prior to need? death?	utopsy findings available occupletion of cause of
Vital F	ician: T	Be	25. Was case referred to medical examiner?	oital:			Other	eath (Check on	ily one)	7	
o	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page:	cate: To	T res 2	1 ☐ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	ER/Outpatien 28b. Time of injury	28c. I	njury at work?	280	-	ence 6 Other (Spe	ecify)
Division	al or Atten s after dea: I Director: d in by the	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stre				Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	ne Hospita n 24 hours ne Funeral pleted fille	Medical	(Check 2Medical Examiner:	n: To the best of my know On the basis of examination actioner: To the best of n	on and/or invest	igation, in my o	pinion, death	occurred at the	time, date an	d place, and due to the	e cause(s) and manner stated.
	To the within To the company		29b. Signature and title of certifier	1 NY		29c. Lic	ense number	12	2	29d. Date signed (Mon 4/19/2011	th, Day, Year)
	3		JACKIE JONES	leted cause of death (Itel		LL AUC	y V	AUEY	RI	TIMONIU	M, MD 2109
	Sta Registr		31. Date filed (Month; Day, Year)	32. Praistrar's Signa	ature	a Kal					

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	for State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F rtificate of			gierie Reg. No.	1 12830
Physician	1. Decedent's Name (First, Middle, I Carmelita Joseph:	,	wlett			2. Date of De Month		3. Time of Death 6:33 P M
/Medical Examiner	4a. Facility Name (If not institution, g	ive street and number)		7,	or Location of Deat	April	4c. County of I	Death
Funeral	Ivy Hall Nursing 5. Social Security Number 6.		e (In yrs. last birthday	Middle I	If Under 24 Hrs		Baltin	. Birthplace (State or Foreign
Director	215-07-6700 Usual Residence of Decedent	1□M 2∭F	96 Yrs.	Months Days	Hours Min.	July 16	y, Year) 1914 M	laryland
iryland show	10a. State 10b. County		10c. City, Town or L			-		10d. Inside City Limits 1
the Ma 28a-f s notified	Maryland Baltimo	ore	Middle R	1Ver			10g. Citizen of Wha	
fiter death with the Ma frems 23a or 28a-fs iner must be notified Funeral Directol	1300 Windlass Dr.			21220			United S	
	11. Marital Status 1 □ Never Married 2□ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2XX No		Specify Yes or No rto Rican, etc.)	Black, Specify:	American Indian, White, etc. white
21215-0036 ed within 72 hours aft yglene. yglene than "ratural"; or t, the Medical Exami t, completed by F	15. Decedent's (Specify only highest		(Giv	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of wo	orking	16b. Kind of Busin	ess/Industry
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yland build be file Mental H arked oth artic event	17. Father's Name (First, Middle, La Micelangelo Elmo	st)				_{me (First, Middle,} ¶a1esci	, Maiden Surname)	
Maryland to 2 should be flict to 2 should be flict to 3 is marked oth traumatic event To Be (19a. Informant's Name/Relationship Kathleen H. Grove	(Type. Print) e/daughter		ing Address (Street Rosepoir		York,	er, City or Town, Sta PA 17404	nte, Zip Code)
Ore,	20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3	☐ Removal from State		osition (Name of ematory or other pla		Date	20c. Location - Cit	
Baltimore, Permit. Pages 1 a Department of Her mportant: If her my Injury or othe more.	4 □Donation 5 □ Other (Spe 21. Signature of Funeral Service Lig	cify)						e, Maryland
Dall permit Depart Import any Ir.	John O. Mil	tehell	20 20	Onn O. Mito	onia Rd.	Timon	ium, MD	Dulaney Valley 21093 P.A
Physician	23a. Per 11. Enter the disease, or constitute. List on Immediate Cause (Final	mplications that caused ly one cause on each lir	11	nter the mode of dyi	ing, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
Medical Examiner	disease or condition resulting in death)	a Due to (or as	a consequence of):	cere				
Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	a consequence of):					
O, e executed an and irial-transit	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
68760, tificate be example g physician as the burian ledical E		d						
Box ath cer or use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	су		23d. Date of Month	
ls, P.O. les that the de gned by the abe detached by Physic	Part II. Other significant condition	s contributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco use contribu	ute to the cause of death?
cords, P w requires that been signed to should be det							Yes 2 No 3	
Vital Records, sician: The law requires to certificate has been signe rector, page 2 should be completed by						24a. Was auto perfi 1 Yes	psy prid ormed? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
r Vital Responsible to the land of the lan	25. Was case referred to medical examiner?	Hospital:		Ot		eath (Check only	one)	
ng Physical directions of the control of the contro	1 Yes 278 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju	ry 28b. Time	ant 3 DOA	iry at		idence 6 Other how injury occurred	
Division or To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral d Medical Certification: To Medical Certification: To	2 Accident investigat 3 Suicide 6 Could not	be 28e. Place of inju	ury - At home, farm, s		Yes 2 No	28f. Location	Street and Number	or Rural Route Number,
Div oital or us after oral Direction by Certification by	4 _ Hornicide	building, et					wn, State)	
o the Hosp thin 24 hou the Funder ompletely findedical	29a. Certifier 1 CertifyIng (Check only 2 Medical Ex	Physician: To the best aminer: On the basis o and manner sta	f examination and/or	investigation, in my	opinion, death occ	ce, and due to the	, date and place, an	er as stated. d due to the cause(s)
Tot with Tou	29b. Signature and title of certifier	s &50,	MD	D	se number	7	29d. Date signed (11
0	30 Name and address of person with Wum (31. Date filed (Month, Day Year)	no completed cause of d	124 Mo	Ce A	renue	Bal	Honore	MD 21221
State Registrar	31. Date filed (Month, Day Year)	32. Registr	ars Signature	les!				
DHMH 17 Rev 1/2001				-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 20 T 1818 Clarence H. Hawkins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** v¹V^{reat} 937 Hours 1 ▼ M 2 □ F Maryland 219-26-2443 73 Director Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Annapolis 1 Tes 2 X No Maryland Anne Arundel ò 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? 23a 21403 USA 962 Old Annapolis Neck Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. "natural", or by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Completed 3 Widowed 4X Divorced Black. Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Seconday (0-12) 7th College (1-4 or 5+) Hygiene. Truck Driver Excavation Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 2 Elsie Evans Clarence H. Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 6658 Shelly Rd. Glen Burnie, Md. 21061 Hilda Evans (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4-20-11 Baltimore, Md. Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) My Mame RARS Pof Pacility Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on wach line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed ng physician as the burial Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No o Day Year by the a g Unknown signed by 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year, Natural 5 Pending after death.

Director; Aft
d in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined completed filled in e Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month Day, Year) Stanature and 29c. License numbe tho completed cause of death (Item 23a) (Type RIVA ROAD, SHI12 ANNAPOUS MD 21401 2629 ANDALL MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05 Day Physician/ 0 4 h 20^Y1^a1 Krista Lanette Herrington 10:55p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Future Care Sandtown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 Days Min. Months Hours 100777947964 Mary land 217-90-4346 Director 46 Yrs Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2532 McHenry Street 21223 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XNever Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: and Mental Hygiene. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Telemarketer unk Be Page 1 and 2 should be filed then tof Health and Mental Hygent: If item 27 is marked oth Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Herrington Lillie Lowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shenay Spruell(daughter 802 Newington Ave., Baltimore, MD 21217 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite Date cemetery, crematory or other place)
on-site Crematory 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Josephadas of Erown Jr. 2140 N.Fulton Ave., Funeral Home PA Baltimore, MD 21217 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ AIDS rminal disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 Live Seath
Pregnant at time of death
Unknown in the past 12 months?
1 Yes 2 No signed by the atte Month Day Year 1 ☐ Yes 2 ☑ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3-Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed? death? 1 🗌 Yes 2 🗌 No 2 1 No Yes Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending 1 Matural work' Division 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mien-p 15 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/20 31. Date filed (Month

DHMH 17 Rev 7/2009

State

Registrar

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ster ames 2011 0930AM Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days 1 反 M 2 □ F Hours Min 0 1 Mpm/h1 Days, } 925 S.Carolina 250-26-8443 86 **Director** Usual Residence of Decedent or 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/ABaltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 2907 Ellicott Dr. 21216 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 No Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Yellow Cab Cab Driver 10th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Marie Jamison Orange James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2907 Ellicott Dr., Baltimore, MD 21216 Beatrice James (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) on-site Crematory 04/20/11 Baltimore, MD Joseph Adress of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21. Signature f Funeral Service License 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician. Medical resulting in death) Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a cons ce of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ Natient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred X Natural injury 5 Pending Accident Investigation Director: 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) within 24 hours a

To the Funeral D 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) D0069441

State Registrar

adras, 3900 L

32. Registrar's Sig

leted cause of death (Item 23a) (Type, Print) Bowlevard, Balthwore, MD 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 201°1 06:30 A M Phyllis Louise Johnson Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Glen Meadows Nursing Home</u> Glen Baltimore Arm Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Hours 10/11/192 New York 110-14-0345 89 Yrs Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Glen Arm 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11630 Glen Arm Road U.S.A. 21057 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other fraumain. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Harold I. Green Jennie Geidel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Johnson, Jr./ Son 6200 Trancas Canyon Road, Malibu CA 90265 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 \cancel{X} Cremation 3 \square Removal from State Hilltop Service Corp. 04/20/2011 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility Towson, MD 21204 Signature of Funeral Service Lic Ruck Towson Funeral Homé, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ ACUTE disease or condition mute Medical resulting in death) Examiner DROMARY ARTSRY DISRASE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atte in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIBRILLATION Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should CONGESTIVE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No Yes 2 No 25. Was case referred to medica To Be completed filled in by the funeral director, 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending 24 hours after death. Funeral Director: A 2 🗆 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 35 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one d title of Certifier RO79544

Registrar DHMH 17 Rev 7/2009

State

STE 4105

ckrf

ho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

701

30. Name and address of person

SUSAN

31. Date filed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Month ()4 18 04:15 2011 D M Jr. Love Keeler 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Thomas More Medical Complex Prince George's Hyattsville Social Security Number 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🛛 M 2 🗆 Months Hours Min. 0370871935 Director 178-26-2991 76 Usual Residence of Decedent 28a-f show 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Prince George's Hvattsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4922 LaSalle Road 20782 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or 1 X Never Married 2 Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Research Biologist Biology 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Keeler Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Pot Spring Road S-726 Timonium, MD 21093 <u>Cardinal Wm. H. Keeler.</u> Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or 04/26/2011 | Baltimore, MD 4 Donation 5 Other (Specify) New Cathedral 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. and Narts 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosdwolū Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 € 9 ☐ Unknown 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Respiratory 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an prior to completion death? page 2 has autopsy performed After this certificate 1 Yes 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Be 2 No Other: Medical Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of country 29d. Date signed (Month, Day, Year) D006368 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1835 University Blvd. E. Suite 208 Hyattsville, MD 20783 Kurup, 31. Date filed (Month, Day, Year) State APR 21 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DWALD 2240 NE OL 062011 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner CUMBERLAND ALLEGIAN 5. Social Security Numberunk If Under 24 Hrs. 9. Birthplace (State or Foreign Country) unk If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 ₹ M 2 □ F Months Days Hours Min 69 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10b County 10c. City. Town or Location 10d. Inside City Limits r then "natural", or items 23e or 28e-f show the Medical Examinar invest be notified at MD 1 ☐ Yes 21 No Allegany Directo Cumber land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 13800 McMullen Hgwy USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give unk 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Western Correctional Institute 13800 McMullen Hgwy Cumberland, MD mportant: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5幫Other (Specify) in state ²², Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** PNEUMONIA fmmediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of Examine requires that the death certificate be executed attending physician end for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the a Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 🗆 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ၉ 2 No Other: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this 28a. Date of Injury (Month, Day Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certlfication: 5 Pending 1 Natural 2 ☐ Accident death. 2 □ No investigation 1 ☐ Yes thef 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signa nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of per eause of death (Item 23a) (Type, Print) COLIN TE 13800 MEMULEN HIGHWAY CUMBERL 07 mp

Registrar DHMH 16 Rev 6/95

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18^{Day} Physician/ April 201^{Year} Douglas Krebs 2101 P M Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death The Johns Hopkins Hospital Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month Day, Year) May 13, 1944 Days Min 1 5 M 2 1 F 175-34-6013 Director 66 PA Usual Residence of Decedent or 28a-f show 10a, State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No Orwigsburg PA Schuylkill 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 14 Maple Road 17961 USA should be filed within 72 hours after death v and Mental Hygiene. 'is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married 2 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Divorced Specify: Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Textile Industry Comptroller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Douglas W. Krebs Sophie Florance Mackalvage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Linda J. Krebs - Wife 14 Maple Road, Orwigsburg, PA 17961 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Durial 2 X Cremation 3 Removal from State 5 Other (Specify) Mountain Crest, Inc. 4-25-2011 Donation McAdoo, PA Signature of Funeral Service Licenses 22. Name and Address of Facility Hamilton Funeral Home, Inc. 116 South Liberty Street, Orwigsburg, PA 17961 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Adenocarcinoma of the Lungs Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examine Due to (or as a consequence of): signed by the attending physician and a be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 🗌 No Yes 2 X No To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🔀 No Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 1 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 April 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St., Baltimore, MD Arvind K. Pandev 21287

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Koutsonouris **Physician** 19 935 am 20 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 F Days 216 - 38-2910 Usual Residence of Decedent Greece 11-27-1928 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 □ No Director MD BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? STREET USA UMBRA 507 21224 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) RETAIL CLOTHING DEAMSTRESS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ZAFERAKIS CANNIS ARGURENIA LAFERAKIS 19a. Informant's Name/Relationship (Type. Print) (Nitre) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARAMA DRIVE FALLSTON, MD 21047 5.Qb 20a. Method of Disposition Koulabos Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE, MD OAK LAWN COMETERY 4-27-2011 21. Signature of Funeral Service License 22. Name and Address of Facility 2134 WILLOW SPRING RD liter Bourimore, mb 21222 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Aspiration Physician 2 hours disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 **N**O 9 Unknown the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: s after death. I Director: After the 1 Natural 5 Pending investigation or Attending Injury 1 Tes 2 No Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hin 24 hours after the Funeral Dire To the Hospital o within 24 hours af Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) pletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res-000

State Registrar

DHMH 17 Rev 1/2001 11595 4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian Howard

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 18 Kelly 2011 2:11 Рм Pamela Jane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A Keswick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March 24 1 □ M 2 🛣 F Months Davs Hours Lowa Director 478-54-2632 66 1945 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director N/A Baltimore 1 X Yes 2 No MD. 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 2927 N. Charles St. 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force
1 Yes 2 Black, White, etc. 1 Never Married 2 XMarried þ 2X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Ex. Director State Forestry State of Maryland other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Rosemary Luke Alovosis Imhoff ge 1 and 2 should by it of Health and Mer : If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2927 N. Charles St. Baltimore, MD. 21218 Charles Kelly/ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Co. 4-27-11 Towson, MD. 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, MD. 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or compl cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
Mon A shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cance Physician/ disease or condition resulting in death) Lung Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has s certificate has director, page 2 perform 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 \square Pending nours after death. 1 Tes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination investigation, in my springing local recognition and the cause (s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature angnitle of certifier 00611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Charles Svile 701 ST State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year HUONG .30P M UU 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Burtonsville Sanctuary at Holy Cross 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 1, 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F 1954 Yrs Vietnam Director 215-96-8463 56 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Wheaton MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 Vietnam 901 Hyde Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 Divorced Specify: Vietnamese Completed the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 2 should be filed within 72 th and Menta! Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Retail 12 Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gioi Tran Lam Luu other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5022 Nicholson Lane Rockville, MD 20852 permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Toan Luu/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 04/22/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death LETASTATIC PATOCELLULAR Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death the Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NCEPHACOPATHY 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No Yes Yes 25. Was case referred to medical Be 26. Place of Death Check only one Other: 1 Tes 2. No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funeral Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Gertifying Nurse Practioner: To the best of my howledge, at the time, date and plane 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year)

our mi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Son ITH

AVE, BALD MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death . 2<u>011</u> Physician/ 10:15 P M April 16, Isabelle A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Debbie & Betty Assisted Living Baltimore If Under 1 Year If Under 24 Hrs, Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthdav) 8 Date of Birth Funeral 1 M 2 XF (Month, Day, Year) ugust 5,1920 Director 218-18-8233 90 August Usual Residence of Decedent 23a or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Md. Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6724 Cedella Avenue 21206 USA Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and Mental Hygiene. is marked other than "natural", or i Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White If Yes, Give Specify 3 XWidowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Federal Reserve Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ permit. Page 1 and 2 should be i Department of Health and Ments Important: If item 27 is marked UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eilene Miller Friend 5724 Cedell Avenue Balto. Md. 21206 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 4-18-2011 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home any 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ver, much 160~ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death the 1 ☐ Yes ∠ 9 ☐ Unknown detached Linknown P.O. s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate has page 2 2 🗌 No Yes 1 Yes 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 X No ALF ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 A Other (Specify) n 24 hours after death.

• Funeral Director. After the pleted filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Pwithin 24 29b. Signature and title of certifier 037573 18,5011

State Registrar 30. Name and address of person who o

31. Date filed (Month

7, bell

DHMH 17 Rev 7/2009

Ave

d cause of death (Item 23a) (Type, Print)

gistrar's Signature

2835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical April Pay 19 2011 Virginia Lambrow 9:30 P M 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death 6612 Graceland Ave. Baltimore 9. Birthplace (State or Foreign Country) West Virginia Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Days (Month, Day, 1 ☐ M 2**X**☐ F Hours Year Director 235-12-2455 91 1920 06. 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore N/A 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral USA 6612 Graceland Ave. 21224 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2x No If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify Specify "natural", Completed 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Construction Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Pazakis Stegroula Constantine Lambrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gus Lambrow/ Nephew Lombard St. Baltimore, MD. 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Greek Orthodox Cem. 4-26-11 Woodlawn, MD. 22. Name and Address of Facility RUCk 1050 21. Signature of Funeral Service Licensee Towson Funeral Home, York Rd. Towson, MD. Inc. 21204 23a. Part 1. Enter the disecte, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final nset and Death Physician/ CORONARY disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ongestive Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregn 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day signed by the a 1 ∐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 **N**0 1 Yes ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Box 68760

Records,

Division of Vital

Registrar

29b. Sian

and title of

RAYMOND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JR MD

29d. Date signed (Month, Day, Year)

3449 Wilkens Ave Baltimore, MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per FH G914 4/21/2011
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year ANNA 23:23 LAYSON 2011 HOPE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL COLUMBIA HOWARD COUNT GENERAL HOWARD ial Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 🗆 M 2 🔀 F Days Min. 618-41-6056 7 **Director** EPTEMBER 16 2003 Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Howard **Ellicott City** 1 Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12225 Carroll Mill Road 21042 U.S.A. . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married "natural", or ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) student elementary school Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zaroogian Mark S. Zagoorian Marcia A. Larson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is 12225 Carroll Mill Road Ellicott City, MD 21042 Marcia A. Larson mother Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State Apr 20, 2011 Marriottsville, MD Crestlawn Memorial Gardens 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) / RUPTURE PULMONARY ANEURYSM HOURS Medical Due to (or as a consequence of) Examiner UNREPAIRED TETRALOGY YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 🗌 No 1 Yes To the Hospital or Attending Physician: 'within 24 hours after death.'

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 1 XYes 2 🗆 No Certificate: To 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie APRIL - MD 060073 14,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEDAR LANE 21044 SYLVIA C. BANK 5755 COLUMBIA, MARYLAND 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Lægible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rita Mary LaVerghetta 10:00 p M 2011 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Summit Park Health & Rehab Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday)
92 yrs. 9 Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Days Hours Min 217-03-3269 MID Director Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 X No MD Baltimore Baltimore o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21208 United States 420 Milford Mill Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ and 2 should be I Health and Ments Peter D'Adamo Carmela Iacovetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond LaVerghetta - son 10194 Owen Brown Road Columbia, MD injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite 1 XBurial 2 Cremation 3 Removal from State APRIL 16, 2011 Pikesville, MD Druid Ridge Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc any. 4112 Old Columbia Pike Ellicott City. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 117 Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MENTIA Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month 1 Yes 2 No Pregnant at time of death g 🗌 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has or Attending Physician: The 1 Yes 2 No Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending nours after death.

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filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 24 29b. Signature and title of certifier ATTENDING 10052948 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NSINDA ME BALTIMONE 21229 State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

11-02868								
Michael Link								

ichael Link		State of Maryland / Department	of Health and Mental	Hygiene	2011 1284
		1- For State Certificate C		Reg.	No.
Physici		Decedent's Name (First, Middle,Last)		2. Date of Death Month April 15, 201	Oay Year 1237 hrs
ledical Exam	mer	Michael James Link 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De		11 1237 IIIS
		313 Limestone Valley Drive # K	Cockeysville		Baltimore County
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		213-78-0161 1 ⅓ m 2□F 5 2 Y	rs. Months Days Hours	Min. 9/4/19!	
10a.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation	-	10d. Inside City Limit
▶		Maryland Baltimore Cockeysv			1 Yes 2 N
arylan 8a-f sl	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
21215-0036 Uld be filed within 72 hours after death with the Maryland Mental Hygiene marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.		313 Limestone Valley Drive # K	21030	l	J.S.A.
h with Pms 23 i be ng	Funeral		Vas Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pu		14. Race - American Indian, Black, White, etc.
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72 hou n "na al Exa	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use	retired)	
5-0036 led within 72 hou Hygiene. other than "nai	Completed	1 Wait			Restaurant
21215-0036 21215-0036 und be filed within 7 Mental Hygiene. marked other than ic event, the Medica	0	17. Father's Name (First, Middle, Last) Bernard G. Link		ame (First, Middle, Mai	iden Surname)
D 212 should be and Ments 7 is mark	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number	ed Soper or Rural Route Numbe	er, City or Town, State, Zip Code)
- 2 T . T		Jeffrey Link / Brother 1647	Daily Dr. Erie	, Colorado	80516
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Dispo	osition (Name of cemetery, other place)	Date 2	20c. Location - City or Town, State
imore Pages 1 ment of F		4 Donation 5 Other Specify: Hilltop			Towson, Maryland
Baltimore, permit. Pages 1 an Department of Her Important: If ite					n Funeral Home, Inc.
Physician	_/	23a. Part I. Enlier the disease, or complications that caused the death. Do not enter	050 York Road the mode of dying, such as cerdia		-
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Card	liovascular Dieo	200	Between Onset and Death
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	F	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
-	Examiner	causs. Enter Underlying Causs (Disease or injury that initiated c			
ited d ansit		events resulting in death) Last Due to (or as a consequence of): d.			
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760, cate b	/Mec	IF FEMALE: 23b. Was decedent pregnant in the			23d. Date of delivery
Box 68760 e death certificate b the attending physical ed for use as the bu	cian	past 12 months?	etal death 3Ectopic pre	gnancy	Month Day Year
Boy e death the att	hysi	1 Yes 2 No 9 Unknown 9 Unknown	Julier (Opcony)		
Records, P.O. Box 68760, The law requires that the death certificate be toate has been signed by the attending physici page 2 should be detached for use as the buri	by P	Part II. Other significant conditions contributing to death but not resulting in the	undertying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
ts, F quires en sign uld be		Chronic Alcoholism		24a. Was an	24b. Were autopsy findings available
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,		29a. Certifier	urred at the time, date and place a	and due to the cause(s	and manner as stated
o the lithin 2 o the l	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated.			
E 2 E 3	Σ	29b. Signature and title of certifier	29c. License number	ME 29	9d. Date signed (Month, Day, Year)
		The odore M. Krog JR, no.	O.C.M.E.	A	April 16, 2011
61		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltim	ore MD 21201	
		31. Date filed (Month: Day Year) - 32. Reishar's Signature	TTT CITI Officer, Dallilli		

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) MOORE Month Year **Physician** 2:27 AM 201 ADri /Medical 4c. County of Death 5. Social Security Number 6. Sex 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Butimore Cuty If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 213-28-8606 1 ☐ M 2 💢 F Months Days Hours MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County No 2 No BALTIMORE **Funeral Director** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11.5.A. CORDELIA 5104 21215 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: BLACK ģ 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL NURSE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Williams BEATT ဂ 19a. Informant's Name/Relationship (Type. Print) DAUGHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/5 GARRISON AVE., BALTIMORE, 20b. Place of Disposition (Name of cemetery, crematory or other place) FRANCES MOORE-FISHER MARYIAND 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Mary /11 4 ☐ Donation 5 ☐ Other (Specify) THE DERRICK 21. Signature of Funeral Service License 4611 PARK HGTS. AVE. , BALTIMORE, Md 21215 23a. Part 1. Enter the disease, or complication at at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION disease or condition resulting in death) Due to (or as a consequence of): (ORUNARY ARTERY if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner -ITPERTENSION Due to (or as a consequence of) Physician/Medical HTPERCIPIDEMIA IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectonic pregnancy in the past 12 months? 1 ☐Yes 2 ☑No Month Year Day 5 ☐ Other (specify) 9 Tunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, After this certificate has been signed by the funeral director, page 2 should be detached Hospital or Attending Physician; 24 hours a

Funeral

Director

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ed other than "natural", or item event, the Medical Examiner

permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other:

Physician

/Medical

Examiner

death with the Marylan

Baltimore, Maryland 21215-0036

within 2.

State Registrar 29b. Signature and title of certifig

SUSAN LIBURGER

31. Date filed (Month, Day, Year) 32. Registrar's Signature

MI)

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

and manner stated.

5200 EASTERN AVE. BALTMORE, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11 18 AM 2011 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death square BalTimore FRanklin HOSPITal Center Rosedale 6. Sex 1 M 2 F If Under 24 Hrs. Social Security Number 7. Age (In yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Month, Day Min Country) Director Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No HMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married within 72 hours after 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give AFK 1955 Specify: WKite Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 permit. Page 1 and 2 Department of Healt Important: If item 2 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 1-Askton Funeral Home Road 2122 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bradley any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Gastrointestinal Hemorrhae Du (or as disease or condition Medical resulting in death) Examiner acute myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records. To the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes Completed ompleted filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural iniury work? s after death 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MDD0061662 address of person who completed cause of death (Item 23a) (Type, Print) 4000 JonaTha .Hanzen FRANKLIN SQUEETE DR Balto md 31. Date filed (Month State Registrar

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		ŀ	30 Name and add	Iress of person v	who completed	d cause of dea	ath (Item 23a) (Type, Pi	rint)	2 00		1711	XII) I	(D) 21	711
クV			LaPrir	cess	Bre	wer.	, mD			4940	Eastern	Avenu	e, Baltim	ore, MD,	21224
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. #4a Per PHY G920 10/25/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ **Agnes Elaine McDonald** Apr 17, 2011 1:15 PM Medical 4a. Facility Name (if not inptitution give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown **Baltimore** Futer Care Old Court 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💆 F Months Days Hours Min. 217-30-4241 78 Director Usual Residence of Decedent or 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d, Inside City Limits the Medical Examiner must be notified at Director MD **Baltimore** Gwynn Oak 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21207 5509 Gwynndale Ave U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 'n, ρ 1 Never Married 2 Married 1 Yes 2 No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker **Own Home** permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louis McDonald Elizabeth Funk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Russell, 3749 Ashley Way Owings Mills, MD 21117 niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Ellicott City, Maryland **Good Shepherd Cemetery** -21-11 4 Donation 5 Other (Specify) re of Funeral Sen 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) THEROSCLE ROTIC CARDIOVASCULAR YEAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir and -transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial ng physician as the burial Physician/Medical been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 1 Yes 2 No this certificate Yes 27 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 \(\subseteq \text{Yes} Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signat erma MI)

Registrar

DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

516-N ROLLINGRO # 108 MD21228

s and address of person who completed cause of death (Item 23a) (Type, Print)

UMARMO

MIVASANITUA

31. Date filed (Month

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Mark Ogle	

Please ⁻	Type or Print in Black Indelible I	nk. Ensure All Copies Are L	egible201	2851
	State of Maniford / Department of	Health and Montal Hygiana		

	1- For State Certificate of Death Reg. No.
Physician/ Medical Examine	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	8600 Geren Road Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	460-78-9987 1XM 2F 55 Yrs. Months Days Hours Min. July 15, 1955 Country)Texas
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21215-0036 Uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner To Be Completed by	Allen Marbury Ogle Martha Elizabeth Porter
MD 21 d 2 should th and Me a 27 is ma umatic ev	Cathy Dormitzer/Partner 8600 Geren Road Silver Spring, MD 20901
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other tinging or other traumatic event, the Med	20a. Method of Disposition 2
Baltir permit. J permit. J permit. Importa injury o	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MO 1251 Peverly I. Heckrotte, P.A. Clarksville, MD 2102 Approximate Interval Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Asphyxia due to plastic bas over head Due to (or as a consequence of):
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executed an and all - transit	d.
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x 687 h certific ending j use as th	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1
P.O. BO) that the death ned by the att detached for by Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
s, P.O. ires that th signed by d be detach	1 Yes 2 No 3 Probably 4 ✔ Unknown
Division of Vital Records, tall or Atteoding Physiciae: The law requires as after death. **I Director: After this certificate has been signed in by the funeral director, page 2 should be entification: To Be Completed	24a. Was an autopsy findings available autopsy prior to completion of cause of
Rec ifficate of r. page	1 ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)
Vital ysiciae this cert directo	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Vother: Scene
ding Ph	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
risio	2 X Accident Investigation Id 4-15-11 Id 1840 hrs Subject asphyxiated self 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number. City
Division o spiral or Atteoding tours after death. orars Director: After filled in by the fure Certification:	4 Homicide Home Silver Spring, Md.
Division of To the Hospital or Attending Physicial 24 hours after death. To the Procental Director: After a completely filled in by the funeral Medical Certification: T	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Fri	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
3	30. Name and address of person who completed cause of death (Item 23a)
OFFICE	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registrar	NWR A L AUT AMIT F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ Jean Peterson 9 Phyllis 4:45 pm^M April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Social Security Numbe 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months Days Hours March 18, 1928 West Virginia 83 235-42-6040 Director Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Virginia Fairfax Springfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22151 U.S.A. 7619 Boulder Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edith Neel Cecil Patton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7619 Boulder St., Springfield, VA 22151 James Peterson (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Rosewood Cemetery 4/13/2011 Lewisburg, WV 4 Donation 5 Other (Specify) Sign Jure of Funeral Service Licensee 22. Name and Address of Facility Wallace & Wallace Funeral Home 102 Jefferson St., Lewisburg, WV 24901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Aspiration Pneumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). Pulmonary Edema for use as the burial-transi Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Severe Aortic Stenosis that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 9 Unknown 1 ☐ Yes 2 E 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemia 24a. Was an autopsy performed? Yes 2X No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? မ ER/Outpatient 3 DOA 1 XInpatient 2 -4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00068160 10 ZUZAK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20814 Kimberly Zuzak, MD 8600 Old Georgetown Road Bethesda, MD

State

Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 April 14. 2:21 P M Ronald Peppers Delano Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ft. Washington Hospital Ft. Washington Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jun.1, 1934 Social Security Number 6. Sex 1 X M 2 □ F 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** TN Country) 76 Director 411-50-1058 2 should be filed watum. -ath and Mental Hygiene.

1.27 is marked other than "natural", or items 23a or 25u-1.

-- *raumatic event, the Medical Examiner must be notified at Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🕱 No Prince George Fort Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 Beech Street 20744 USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No.
If Yes, Give 1953Year or Dates. 196 Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 1961 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Superintendent Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vardy Peppers Pearl Morgan ige 1 and 2 should but of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Frances Peppers - Wife 313 Beech St., Ft. Washington, MD other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 X Burtal 2 Cremation 3 Removal from State 4 Onation 5 Other (Specify) Culpeper National 4-18-11 Culpeper, VA Name and Address of Facility Lore-English Funeral Home 1190 James Monroe Hwy., Culpeper, VA 22701 uneral Service Livensee Sign ture of Mun Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer arrythmia Onset and Death Immediate Cause (Final Pnysician/ al diac disease or condition Medical resulting in death) Due to (or as a consequence of) artero **Examiner** disease COTONary Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of physician and the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23h Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician; The law certificate has autopsy performed page, death? 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital _2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA မ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) MD 14,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11711 Livingston Rd., Ft. Washington, MD Deepak K. Sachdeva, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 1 2011 acke

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Helen Victoria Pacholski 2011 11:15pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Heritage Center Dundalk If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛚 F Hours 12-20 1920 Maryland 90 219-10-7830 Director Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Baltimore Co. Dundalk 10e. Street and Number 10g. Citizen of What Country? Funeral 7922 Diehlwood 21222 USA Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3

Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Clerical Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stanislaus Grabecki Prakseda Kendrzejewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8913 Yvonne Avenue Perry Hall, MD 21236 Joan Brown-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4-25-2011 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) Rosary Cem. 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Function Service-Licens 1201 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner NGESTIVE HEART FAIURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed the burial-transi and attending physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death be detached P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sinn Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 Division of Vital 25. Was case referred to predical completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Tes 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA s after death. 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Accident 1 Natural 5 Pending work' 1 Tes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated DQ' Dundalk MD 21222 State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03-31-2011 Alvin A. Padgett, Jr. 08:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Marlboro Prince George's 13924 King Gregory Way If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Hours 81 0601 2 2 1 2 2 9 DC **Director** 579-30-3731 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MDCalvert Huntingtown 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? an "natural", or items 23a o Medical Examiner must be Funeral 5590 Stephen Reid Road 20639 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Black. White, etc. ģ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates. 1944-50 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. d other than " event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Electrician Be permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alvin A. Padgett, Sr. Edith Bunch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20639 19a. Informant's Name/Relationship (Type, Print) Robert Padgett, 5590 Stephen Reid Rd., Huntingtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cem. 04-04-2011 Suitland, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 20746 118ha Cedar Hill FH,4111 PA Ave.,Suitland, M10/6/6 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Prostate Cancer Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examiner Due to (or as a consequence of) the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Yes 2 No 1 ☐ Yes 2 ☐ Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: son's home ည 1 Tes No 4 Nursing Home 5 Residence 6 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation s after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9200 Basil Ct., Ivan Zama, MDSte. 200 Largo, MD 20774 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ 16 2011 Douglas Fontaine Pollard 2:20 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Keswick Multi Care Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🛛 M 2 □ F Hours June 17 1942 MaryTand 213-40-6672 68 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Glyndon Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral United States 21071 4427 Butler Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Stock broker finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is markωα any injury or αtt. Walter Weir Pollard Jr. Eleanor Skyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glyndon, MD Frances D. Pollard/wife 4427 Butler Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Green Mount Crematory Apr. 19,2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) All Parpe and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
MD 21212 6500 York Rd. 21. Signature of Funeral Service Licensee Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Advances disease or condition resulting in death) Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 Yes 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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D71040

Please Type or Print in Black Indelible Into Engura All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 4 0131 M Physician/ 2011 Perkins Arthur Luther Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Carroll Westminster Carroll Hospital Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. Sept 14, 1918 Country)
Maryland 1 🛣 M 2 🗆 F Yrs. 92 Director 161-14-7856 Usual Residence of Decedent 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Finksburg Carrol1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral U.S.A. 21048 1901 Suffolk Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. WW II 11. Marital Status Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 tal Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) C & P Telephone PBX Installer Be 18. Mother's Name (First, Middle, Maiden Sumame) traumatic event, 17. Father's Name (First, Middle, Last) should be filed and Mental H is marked of ၉ E1sa Pugner F. Perkins Arthur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or with 21048 Finksburg, Maryland 1901 Suffolk Road Bertha Perkins 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Woodlawn, Maryland 4/18/11 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 11824 Reisterstown Road 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Reisterstown, MD 21136 ELINE FUNERAL HOME J. Wayne Osterling 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final VENTRICULAR Physician/ disease or condition resulting in death) Medical HEART Examiner ATHEROSCLEROTIC Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 attending IF FEMALE 23d. Date of delivery use 23b. Was decedent pregnant Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: The law requires that the death for ed by the a detached f 9 Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by be det Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Records. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? cate has page 2 s 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 1 No 1 Inpatient 2 PER/Outpatient 3 IDOA မ 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 28a. Date of injury Certificate: 27. Manner of Death injury (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie hachody warms DOUIS 200 April 15, 2011 , 700 A poole Rd. WESTMINSTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAGANNA CHITRACHEDU 32. Registrar's signatur 31. Date filed (Month, Day, Year) State 21 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D2011 Physician/ April 19, 11:55 PM Pfautz Anna Lou Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Kensington 10030 Kensington Parkway If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Date of Disc. (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min Country) Kansas 1 □ M 2 🔀 512-22-6838 Director 83 August Usual Residence of Decedent f show 10a, State 10b. County 10c. City, Town or Location 10d Inside City Limits be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 K Yes 2 No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20895 10030 Kensington Parkway 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wallis Hoch permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Frances Randels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leanne Pfautz / Daughter 10030 Kensington Parkway Kensington, Maryland 20895 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Apri1 22, Montgomery Crematorium Inc. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 eral Service Licens Robert Addrespointiney Funeral Home, Bethesda-Chevy Chase, Inc MO1607 7557 Wisconsin Avenue Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ Metastatic Breast Cancer to vears +4 months disease or condition , Medical resulting in death) Examiner intrathoracic nodes Sequentially list conditions, if any list line in the cause. Enter Underlying Cause (Disease or linjury that initiated events Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown g Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? 1 ☐ Yes 2 🛛 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 🗆 Yes 2 🔀 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury X Natural 5 Pending 1 ☐ Yes 2 ☐ No after death Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signat ne and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Rabistrar's

Carolyn Hendricks,

Date filed (Month, Day,

APR 21

D37236

6410 Rockledge Drive #506, Bethesda, Maryland 20817

20 APR 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death . Day 2011 April Physician/ Allen 16 8:45 AM Margie Lou Parsons Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Glade Valley-Genesis Healthcare Walkersville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 24, 1925 1 🗆 M 2 🗶 F Months Days Hours Min. South Carolina 249-32-7420 85 **Director** Usual Residence of Decedent 28a-f shov pernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 Yes 2X No Maryland Frederick Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21704 5955 Quinn Orchard Road #155 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify. 3 X Widowed 4 ☐ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) School System Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ethel Burden С. Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5536 Etzler Road, Frederick, Maryland 21702 Richard Parsons / 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Aprií 1 X Burial 2 Cremation 3 Removal from State Norbeck Memorial Park 2011 4 ☐ Donation 5 ☐ Other (Specify) Olney, Maryland Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. S YZ eth Immediate Cause (Final Ph_sician/ OBSTRUCTIVE CHBONIC PHLMONARY disease or condition , Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death has been signed by the e e 2 should be detached Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy After this certificate hat funeral director, page performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 욘 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 7/2009

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Physiciar Medica		Michael James	Quick		1, 201 3:30 PM
Examine	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dear	th	4c. County of Death
Funeral		Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Rockville (ay) If Under 1 Year If Under 24 Hrs		Montgomery 9. Birthplace (State or Foreign
Director		214-35-7849 1 M 2 ☐ F 22 YI	Months Days Hours Min	July 3,	1988 Maryland
fand show d at	to	10a. State 10b. County 10c. City, Town of	or Location		10d. Inside City Limits
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th the 3a or t be n	Funeral Director	10e. Street and Number	10f. Zip Code 21771	10	og. Citizen of What Country?
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or ite	by F	1 Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	to Rican, etc.)	Black, White, etc.
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/lan d be fi /lenta nrked itic ev	욘	William Michael Quick	Virg	inia Ripp	ey
Maryland 2 should be filed th and Mental Hy 27 is marked oth traumatic event			Mailing Address (Street and Number or R		
and 2 tealth					dge, Maryland 21791
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition 1 Burial 2 X Cremation 3 Removal from State Monte of Monte of Complete C	Disposition (Name of crematory or other place) nery orium, Inc. 20	11 18,	20c. Location - City or Town, State
Itim iit. Paratmer artmer ortant injury		4 □ Donation 5 □ Other (Specify) Cremato 21. Signature of Principal Service Licensee/			Bethesda, Maryland
Balt permit Depar Impor any In	h 1	Epiglete agreet M01305		enue, Rockvi	ille, Maryland 20850-2805
		23a. Part . Exter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardia	c or respiratory arres	t, Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificat has teen signed by the attending physicic completed filled in by the funeral director, page 2 s rould be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic Newnancy 5 ☐ Other (specify)		23d. Pate of delivery Month Day Year
O. E. true of the by the tache	Phys	g 🗀 Unknown	Alexander de de la Companya de la Co	1	
P.		Part II. Other significant conditions contributing to death but not resulting in Anticoagulated for Pulmonary Embo			acco use contribute to the cause of death? $ imes 2 f X$ No $3 \Box$ Probably $4 \Box$ Unknow
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Division of Vital Records, P.O. ral or Attending Physician: The law equires that the safter death. In Director: After this certificat has been signed by ed in by the funeral director, page 2 should be detacted.	Completed by	Thrombosis, Motor Vehicle Acciden Injuries, Facial Fracture, Wired		24a. Was an autopsy perform 1 XX Yes 2	prior to completion of cause of
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hysic his ce	P	1 X Yes 2 ☐ No 1 X Inpatient 2 ☐ ER/Outp			nce 6 Other (Specify)
ling P	ate:	- Natural 3 - Tending 00/16/10011 11	ury work?	28d. Describe hov	
Sion Attenc death ctor: /	Certificate:	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm	.30 11		chicle Accident eet and Number or Rural Route Number,
Divi		4 Homicide determined building, etc. (Specify)		City or Town, Harrison	State) ville Rd., Mt. Airy, Md
Hospit 24 houn Funera eted fille	Medical	29a. Certifier (Check (Check only one) 1 X Certifying Physician: To the best of my knowledge, de conly one) 3 Certifying Nurse Practioner: To the best of my knowledge, de conly one) 3 Certifying Nurse Practioner: To the best of my knowledge, de conly one) 1 X Certifying Nurse Practioner: To the best of my knowledge, de conly one) 2 Certifying Nurse Practioner: To the best of my knowledge, de conly one) 2 Certifying Nurse Practioner: To the best of my knowledge, de conly one) 2 Certifying Physician: To the best of my knowledge, de conly one) 3 Certifying Physician: To the best of my knowledge, de conly one) 3 Certifying Physician: To the best of my knowledge, de conly one) 3 Certifying Physician: To the best of my knowledge, de conly one) 3 Certifying Physician: To the best of my knowledge, de conly one) 3 Certifying Physician: To the best of my knowledge, de conly one) 3 Certifying Physician: To the best of examination and/or	nvestigation, in my opinion, death occurred	and due to the caused at the time, date and	e(s) and manner as stated. I place, and due to the cause(s) and manner sta
To the within To the comp	2	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
		I Amare Abese, MD	D000525	57	April 18, 2011
4		30. Name and address of person who completed cause of death (Item 23a) (Ty Amare Abebe, MD 9901 Medical Cent	_{pe, Print)} er Drive, Rockvill	e. Marvlar	nd 20850
State	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	or Direct Mockville	_,arj <u></u> ar	
Registra		APR 2 1 2011 Summer & parker	/		
DHMH 17 Rev 7/20	09	Part of the second of the seco			

ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#1perpHYS, G914, 4/21/2011, WS
State of Maryland / Department of Health and Mental Hygiene, amend #18 Per FH 6214/164/26/2014thJH 1. Decedent's Name (First, Middle, Las Ruth Louise Nesbitt Rice 2. Date of Death 3. Time of Death Physician/ LOUISE RIF - NEGB,7= 4:20 PM 2011 04 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LUCH RAVEN TIMORE AL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2**X** F Months Days Hours Min (Month, Day, Year) Country Director 249-36-9324 SC 88 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits with the Maryland Director Baltimore 1 X Yes 2 ☐ No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 4002 Belle Ave within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 ☐XWidowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montebello State and Mental Hygiene. 12th grade College (1-4 or 5+) Hospital Occupational Therapist other traumatic event, Be 18 Name (First, Middle, Maiden Surname) should be filed 17. Father's Name (First, Middle, Last) မ Elvelyn Nesbitt James Nesbitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 4107 Windmill Cir., Randallstown, Md 21133 Eldridge Rice Jr-Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 4/22/2011 Owings Mills, Md Sanature of Funeral Service-License March F/H West erone a nom PRUV 21215 4300 Wabash Ave, Baltimore, Md Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ GESTIVE heart failure m resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Dav Year ed by the a Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown been signated the 24b. Were autopsy findings available prior to completion of cause of 24a. Was an as e 2 autopsy performed? Yes 2 No page death? certificate 2 . No 1 🗌 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Hospital 2 1 No Other: 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After injury work?
1 Yes 2 No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation ₃ □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contifying Number Fractioner: To find out of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Apr. 117, 2011 057239 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raves Bonlevard, Baltimpe MD 21218 SUNESA Shandah 3900 Coch 31. Date filed (Month, Day, Year) APR 2 1 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar Amend Item 2State of Maryland 14,04	728726911dfiBlth ar rtificate of Death		giene Reg. N2 0 1 1	12861
	Physicia	an	1. Decedent's Name (First, Middle, Last) Smrlly Jane Ruth		2. Date of Dea Month	Day Year	3. Time of Death
مان مع	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of [Death	4c. County of Dea	ath
and the second	of.		Manor Care - Ruxton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	TOWSON If Under 1 Year If Under 24	4 Hrs. 8, Date of Birt	Baltimor	rthplace (State or Foreign
~	Funeral Director		216-03-3127 3. Sex 7. Age (iii yis, last birtilady) 91 Yrs. 1 □ M 2 M F 91 Yrs. 1 □ M 2 M F 1 □ M 2 M 2 M F 1 □ M 2 M 2 M F 1 □ M 2 M 2 M F 1 □ M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M		Min (Month, Da	y, Year) C	Maryland
	pur w		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Lo	cation			10d. Inside City Limits
	Maryla -f sho	tor		ville			1 □Yes 2XXNo
	th the	Jirec	10e. Street and Number	10f. Zip Code	<u> </u>	10g. Citizen of What C	Country?
	ath wi	ral	1840 Reisterstown Rd.	21208		United Sta	
980	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show umatic event, the Mcdeal Eventher must be notified at	by Funeral Directo	1 □ Never Married 2 🕅 Married 1 □ Yes 2 🕅 No	Was Decedent of Hispanic Origir if Yes, specify Cuban, Mexican, f 1 □Yes 2 ሺ No <i>Specify:</i>	n? (Specify Yes or No- Puerto Rican, etc.)	Specify	
altimore, Maryland 21215-0036	hin 72 hore. e. an "natur. Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most o DO NOT use retired)	of working	16b. Kind of Business	s/Industry
21	ed wit tygien her tha		12 s	tock room	At A Compa Address	retail	
and	d be fill ental H ced otl	Be c	17. Father's Name (First, Middle, Last) James Garfield Swanson		s Name <i>(First, Middle,</i> aret Lilli:	,	
ary	is 1 and 2 should be filed work Health and Mental Hygie Item 27 is marked other the other traumatic event, the	2		ng Address (Street and Number	or Rural Route Numb	er, City or Town, State,	Zip Code)
Ž,	and 2 lealth a m 27 is her tra	1	3 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Sweetbriar Lar		ir, MD 210	
Jore	Pages 1 nent of H int: If iter iry or oth			sition (Name of natory or other place)	Date 22 2011	20c. Location - City o	
Ħ	permit. Page Department (Important: If any injury or once.		A	erd Cemetery Api 3. Name and Address of Eacility			
ñ	Dep Imp any	0 2	Dobal D. Mitchell 6:	Name and Address of Facility itchell-Wiedefe 500 York Rd.	Baltimore,	MD 21212	•
	Physician /Medical Examiner		23a. 1. Enter the disease, or complications that caused the death. Do not enter the clock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	Intracrani Vulvar Can	ial Hemorri	nage	Approximate Interval Between Onset and Death
8760,	cate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, body is the first cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Our to (uras a nonsequence of): c. Due to (or as a consequence of):				
P.O. Box 6	the death certifi yy the attending I ached for use as	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of d Month	lelivery Day Year
rds, F	w requires that s been signed t should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		obacco use contribute Yes 2 ☐ No 3 ☐	to the cause of death? Probably 4 Unknown
<u>~</u>	The ate h	Completed			1 □ Yes	psy prior to death? 2 No 1 1 Ye	
	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 1 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	lau.	of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death only o	one) dence 6 □Other (Sp	necify)
n of	ling Phys	on: To	27. Manner of Death 1 M Natural 5 Pending (Month, Day, Year) 28b. Time of Injury			how injury occurred	Jeony)
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	M		Street and Number or wn, State)	Rural Route Number,
	he Hospita in 24 hours he Funeral pletely fille	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation in my opinion, death	h occurred at the time.	date and place, and d	ue to the cause(s)
	Voit Con	N	and manner stated. 29b. Signature and title of certifier Afternal and address of person who completed cause of death (Item 23a) (Type, Prichard and M.D. 8415 31. Date filed (Month Pay, Year) 22. Registrar's Signature	29c. License number D0059 2	283	April	nth, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Richard Addo, M.D. 8415	Bellona La	me #21	6. TOWS	on MD 21204
ı	Sta Registra		31. Date filed (Month Day Year) 22. Registrar's Signature APR 2 1 2011	Kel		(,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 201 20:12PM George Robert Raver, Sr. pri /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital - Baltimore more (8. Date of Birth (Month, Day) Aug. 2, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 M 2 □ F Months 74 1936 MD Director 214-34-4797 Aug. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, Ir a Modical Examiner must be notified at 1 ☐ Yes 2X No Director Owings Mills MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 40 Cedarmere Road 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🕅 No Specify: White Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Painting 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Edna Buchman George Elmer Raver 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Pages 1 and 2 street of Health 2 Wife 40 Cedarmere Road, Owings Mills, MD 21117 Linda Raver Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Mem. Gardens 4/23/11 4 ☐ Donation 5 ☐ Other (Specify) Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road 23 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Eline Funeral Home, Reisterstown, MD 21136 Approximate
Interval Between
Onset and Death
WEEKS Immediate Cause (Final pheumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): interstitial lung disease Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-trans attending physician for use as the buria Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 5 Other (specify) been signed by the should be detached 1 ☐Yes 2 ☐ No Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

5

patient

1D Sinai Hos

use of death (Item 23a) (Type, Print)

			for State	State of M	laryland / Dep		of Health of Death		lental Hy	_	2011	12863
			Registrar 1. Decedent's Name (First, Middle,	l ast)		runcate	or Deatri		2. Date of De	Reg. N	16:- 4 1	1 10 10 7 0
	Physicia Medic		Barbara M. Ro	binson							² 2011 Year	3. Time of Death 09:25 P M
	Examir	ner	4a. Facility Name (if not institution,	•			wn, or Location	of Death			c. County of De	
			Stella Maris Ho 5. Social Security Number 6. Social Security Number			Timon:		04.11			Baltimor	
	Funeral Director		218-14-0180	1 M 2 X F	ge (In yrs. last birthday) 87 Yrs.	If Under 1 Months [Days Hours	Min.	8. Date of Bir (Month_Da 06/17/	192	3 Ma	irthplace (State or Foreign ountry) ry Land
	od te	<u>_</u>	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ocation					-	10d. Inside City Limits
	arylar a-fsh ified	Director	Maryland Baltimo	ro.	Timonium	Journal						1 Yes 2 X No
	or 28	늅	10e. Street and Number	re	TIMOTITUM	10f. Zip Co	ode		· I	10a. C	Citizen of What C	
	with t	Funeral	2525 Pot Spring	Road S-715		210	93				S.A.	,
	tems er m	틢	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Deceden	t of Hispanic O	rigin? (Spe	cify Yes or No-		14. Race - Am	erican Indian,
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	If Yes, Give	No		Cuban, Mexica X No Specif		Rican, etc.)		Black, Wh	
9	hours natura ical E	lete	15. Decedent			dent's Usual C				16h	Kind of Busines	
215	in 72 e. ian "r Med	Completed	(Specify only highest Elementary/Seconday (0-12)	grade completed) College (1-4 or :	life I	kind of work of OO NOT use re	done during mo tired)	st of worki	ing	100.	Talla of Basiles	o madaty
7	ygien /gien rer th			J	Balti	more C	ounty S	chool	Teacher	Ec	ducation	1
Maryland 21215-0036	be filed ental Hy- ked oth ic event	To Be	17. Father's Name (First, Middle, La				i		e (First, Middle,		n Surname)	
3	should be file n and Mental H 7 is marked o raumatic eve	-	Valentine Ruppe					ilia	Saver	_		
Ma	2 sho th and 27 is 1		19a. Informant's Name/Relationship Melvin Robinson/	, ,,, ,, ,, ,,							or Town, State, 2	
	and Heal tem other		20a. Method of Disposition		20b. Place of Disp				Z IOWS		MD 2128 Location - City of	
mo	ent of lent of little it it it		1 Burial 2 X Cremation 3 4 Donation 5 Other (Sp		Hilltop S	matory or othe ervice					wson, Ma	
Baltimore,	permit. Page 'Department or Important: If any injury or once,		21. Signature of Funeral Service Lic				Address of Facil		vson, M			il y land
			unyna	leerdu				inera]	Home,	Inc	1050	York Road
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final	omplications that caused y one cause on each line	d the death. Do not ent e.	er the mode o	f dying, such as	s cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
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-	Examiner			Due to (or as	a consequence oi):							
		iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):							
	outed nd ransit	Examiner	Cause (Disease or linjury that initiated events	c								
	death certificate be executed ne attending physician and ed for use as the burial-transit	a E	resulting in death) Last	Due to (or as	a consequence of):							
90	ate be ohysic the bi	dical	•	d								
687	ertific ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy							
Box 687	attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic preg				- 1	23d. Date of d Month	elivery Day Year
B.	the de	hysi	1 Yes 2 No 9 Unknown	9 🗌 Unknown								
P.O.	To the Hospital or Attending Physician: The law requires that the de within 24 hours are dreath. To the Funeral Director, Affei this certificate has been signed by the completed filled in by the fune al director, page 2 should be detached	by P	Part II. Other significant condition	s contributing to death b	out not resulting in the	underlying cau	se given in Par	t I.	23e. Did t	obacco	use contribute	to the cause of death?
ds,	quire	ted							1 🗆	Yes 2	2 No 3 □	Probably 4 🗌 Unknown
CO	has be	Completed							24a. Was auto	psy	prior to	utopsy findings available completion of cause of
Be	: The la cate ha	S								ormed?	death?	es 2 🗆 No
ital	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other:	ath (Check	only one)			
<u>\$</u>	Phys this al dii	년 :	1 Yes 2 No 27. Manner of Death	1 ☐ Inpati	ient 2 ER/Outpatie		4 🗆 N		me 5 Resident			cify) HOSPICE
nc	nding ath. :: Afte e fune	icate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investiga	(Month, Da	y, Year) injury	м	Injury at work? 1 Yes 2		edd. Describe i	iow inju	ary occurred	
Division of Vital Records,	r Attel er dez rector by th	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be	ury - At home, farm, str	eet, factory, of	ffice		28f. Location (S City or Tox			ural Route Number,
ā	oital c urs af ral D											
	To the Hospital or Attending within 24 hours are death. To the Funeral Director: After completed filled in by the fune.	Medical	(Check 2 L Medical Exa	hysician: To the best of nminer: On the basis of e lurse Practioner: To the	xamination and/or inves	tigation, in my	opinion, death of	occurred at	the time, date a	and plac	e, and due to the	cause(s) and manner stated
	To th e within 2 To the сощре	2	29b. Signature and title of certifier	dise Flactioner, to the	best of my knowledge,		cense number	te and place	e, and due to th		ate signed (Mon	
			> assino	1 CAMP		R	14970	72		41	18/201	11
	.04		30. Name and address of person wh	o completed cause of d	eath (Item 23a) (Type, I	Print)				-//	, 0, 001	•
	104		JACKIE JONES, C	RNP 2300 I	DULANEY VAI	LEY RD	. TIMO	MUINC	, MD 21	093		
	Stat Registra		31. Date filed (PR), 2 ^{ay} 1 ^{ve} 201	32. Registra	ar's Synature	1						
	3,041											

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland	-	rtment ificate			nd Me		giene Reg. No	011	Marin Co.	2864
4	Physici /Medi		1. Decedent's Name (First, Middle, L	Sayn	ure		51	^		1	Date of Dea	ath Day	3071	12	ime of Death ! 43 P M
	Examir	ner	4a. Facility Name (III not institution, g Johns Hopkins Bayv		enter	,	4b. City, To		Location of I	Death		4c. C	ounty of Deatl	h	
11	Funeral Director			Sex 7. Ag	e (In yrs. las	t birthday) Yrs.	If Under 1		If Under 24	Min.	Date of Birt (Month, Day Ct. 8	y, Year)	9. Birt Cou	hplace (Suntry) W Yo	State or Foreign
	w w		Usual Residence of Decedent 10a. State 10b. County	1		Town or Loc	ation							10d. Ins	side City Limits
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show with, the Medicel Examiner must be notified et	Director		ltimore	100. 01.9,	1041101 200		unc	la1k						∐Yes 2X No
	with th	Dire	10e. Street and Number	-			10f. Zip-0						n of What Co		
	sath v	Funeral	1712 Langport A	Avenue	Ever in II S	142.14	/ac Departs		21222	n? (Specif	Voc or No		ted St	_	
10	ter de	Fu	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?		IS. V	Yes, specif	y Cuba	lispanic Origir an, Mexican, F	Puerto Ric	an, etc.)	'	Black, White		icii,
036	urs af	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2∑	No	Specify:			8	pecify:	W	hite
5-0	72 ho natura licel E	eted	15. Decedent's (Specify only highest g			16a. Deced			oation during most o	of working	- 1	16b. Kin	d of Business/	Industry	
21215-0036	vithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5		`life. D U.S. A	O NOT use	retired	y.S. Po	_	ffice	II.	nited	Stat	es Gov.
2	filed v Hygie ther t	ပိ	G.E.D. 17. Father's Name (First, Middle, Las	t)		U.D. Z	Triny				First, Middle,				
au	ld be ental ked o c eve	To Be	Hector Saum	ire					Lau	urett	e Lan	dry			
Maryland	shou and M s mar umati	_	19a. Informant's Name/Relationship										Town, State, Z)
Σ	and 2 salth a n 27 is		Mrs. Mary Ann S	aumure (Wit	e)	1/17	Lang	gpo:	rt Aver	nue	Dunda				
nore	ages 1 ent of Hi t: If Iter y or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		cen	ce of Dispos netery, crem S . of	atory or oth	er plac	em. 4	Date 23/2/			ition - City or		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23a or 28a-f show entry injury or other treumatic event, the Medicel Examiner must be notified et once.		21. Signature of Furieral Service Lice			22. I	Name and	Addre	ss of Facility Funer	al H	ome of		dalk, and 21		yrand
	TO = 0 0		23a. Part 1. Enter the dilease, or co	polications that caused	the death.	Do not ente	922 W	ise	Ave.	Dunda ardiac or r	alk, Mespiratory a	lary⊥a rrest.	and 21	Appr	oximate
- 3	Physician /Medical Examiner		shock, or heart fails e. List only immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	o. UM	ONI	a							Interv	val Between of and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b Due to (or as	a conseque	nce of):									
ć	ate be executed hysician and the burial-transit	l iii l	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a conseque	nce of):									
3760,	ate be hysicii the bu	dical	•	d											
O. Box 68	The law requires that the death certificat te has been signed by the attending phypage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1	2 Fetal d	léath 3 🗌	Ectopic pre Other (spe		у			23	d. Date of del Month	ivery Day	Year
, P.O	that the ed by detact	by Pr	Part II. Other significant conditions	contributing to death b	ut not result	ting in the u	nderlying c	ause g	iven in Part I.		23e. Did t	obacco us	e contribute to	the cau	se of death?
rds	w requires tha been signed I should be de										1 □ '	Yes 2 □	No 3□Pr	obably	4 Unknown
Records,	The law rec ate has beer page 2 shor	Completed								_	24a. Was autop perfo		24b. Were au prior to death? 1 ☐ Yes	completi	ndings available on of cause of
		Be C	25. Was case referred to medical examiner?					_		f Death (C	heck only o				
of V	5 0 D	ဂ္	1 ☐ Yes 2 No	Hospital: inpatie		R/Outpatient			4 🗆 Nursi				Other (Spec	cify)	
E C	ding Ph h. After thi funeral	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Day	y Year) 2	8b. Time of Injury	м 28	c. Injur Wor	k?		d. Describe h	now injury	occurred		
	r Attend ter deatl rector:	Certification:	 Arbident investigati 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine 	be 28e Place of init		e, farm, stre			Yes 2 □ No		Location (City or Tow		Number or R	ural Rou	te Number,
	Hospital Hospital Hours Funerei tely fillec	edical Ce		Physician: To the best of aminer: On the basis of	examination										cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner sta	iteu.			Licens	e number			29d. Date	signed (Monti	h, Day, Ye	ear)

State Registrar

DHMH 17 Rev 1/2001 11595

4940 Eastern Avenue, Baltimore, MD, 21224

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Month Bernard Leroy Stansbury 19, 2011 7:00 A^M Apri1 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Center Baltimore Co. Timonium Social Security Number 8. Date of Birth (Month, Day, Y Sept. 2, 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F ,1935 Hours 213-32-4667 Country) Maryland Yrs. Director Sept. Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director errit. Page 1 and 2 should be filed within 72 hours after death with the Maryla epartment of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sing injury or other traumatic event, the Medical Examiner must be notified. Catonsville MD Baltimore 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Winters Lane Apt. 103 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🙀 Married þ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry Steelworker 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Bloom William E. Stansbury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Bernard L. Stansbury, Jr. 18 Juniper Road North Reading, MA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Sacred Ht. of Jesus Cem 4/25/2011 Dundalk, Maryland 4 Donation 5 Other (Specify) 21. Signature of Janeral Service Lice Dundalk, Inc. le 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the illisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) COLON CANCER Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 2 **X** No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

State Registrar

2:00

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29a. Certifier

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CRNP

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

MD 21093

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death ^{Day} 2011 April Physician/ Wilma Grace Shostak 18 4:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, 384-26-4547 81 Michigan **Director** Aug Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18735 Curry Powder Lane 20874 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Executive Assistant Engineering Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Leland Adams Edna Marie Brunner injury or other traumatic I and 2 should b f Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7833 Mount Woodley Place Alexandria, VA 22306 Belinda Byrd/daughter permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other I 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 04/20/201| 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licenses Colong Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 5ep515 disease or condition Medical resulting in death) Due to (or * a consequence of): Examiner decubitus alcers multiple Sequentially list conditions If any leading to immediate cause. Enter Underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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Suicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 00068080 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive, Rockville, 9901 MD Medical Jalli 32. Registrar' Signatu State Registrar

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Baltimore,

Division of Vital Records, P.O. Box 68760

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State Registrar BLVD, MD-21221

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA SBAM. 709. BASTBRN

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH Mary K Scheeler 154P M Medical 4a. Facility Name (if not institution, give street and number) Examiner County of Death
Baltimore 4b. City, Town, or Location of Death Gilchrist Hospice Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X F Months Days Hours Min. 214-24-9859 June 16, Year 1927 Maryland Director 83 Usual Residence of Decedent 28a-f shov 10a. State the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 X No MD Baltimore Towson 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? with 1 Funeral items 23a 800 Southerly Road 21286 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: 'natural", Completed 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) attorney 1aw Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Archer Preston Scarborough Jessie Scarborough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code charles Scheeler/spouse 800 Southerly Road #1129 Towson, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) State Anatomy Board 655 W, Baltimore Street rector <u>Baltimore, MĎ</u> 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ COROBROVASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequence of, cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Pregnant at time of death Day Year 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPORTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 1No 1 Yes the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? HOSALO 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certified

APR 2 1 2011

on who completed cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11'50PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner A Me diCALCENTER TMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 87 Months Hours Min. Oct. Pay, Year 923 Pennsylvania Yrs. **Director** 194-14-2579 Usual Residence of Decedent 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No Virginia Frederick Winchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1209 Baker Lane 22603 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever in 0.5.

Armed Forces?

1 ☒ Yes 2 ☐ No 1943

If Yes, Give
Year or Dates. 1945 Black, White, etc. ģ 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Diesel Mechanic Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Adams Swanger Sarah Jennie Vaughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Geraldine Swanger (Wife) 1209 Baker La., Winchester, VA 22603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4/18/2011 Culpeper National Culpeper, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lones Funeral Home
228 S. Pleasant Valley Rd., Winchester, VA 21. Signature of Funeral Service Licensee First. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest that so, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to ! r as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes 2 12 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending s after death.

Director: Aft d in by the fur 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

State

DHMH 17 Rev 7/2009

Registrar

CLAY diy

10 NORTH GREENE Street Bactimore MD 21201

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MURESAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ,Day 2011 Physician/ April 18, Martha Snyder 12:35 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk 8424 Kavanagh Road Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. (Month, Day, September 219-16-3556 86 **Director** Maryland Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director Baltimore Md. Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? þe Funeral items 23a 8424 Kavanagh Road 21222 USA must permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturaly, or items any injury or other traumatic event: the Medical Evaminar mus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Lever Brothers 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Kolodziejski Carrie Rogowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Snyder Jr. Husband 8424 Kavanagh Road, Dundalk, Md. 21222 t of Healt : If item ? Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 21, 1 X Burial 2 Cremation 3 Removal from State Dundalk, Maryland Sacred Heart Of Jesus 4 Donation 5 Other (Specify) 2011 Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 21. Signature of Fluorial Service Licenses c mplications that caused the death. D my one cause of ach line. t enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a d A equence of **Examiner** C Sequentially list conditions, cause (Disease or iinjury Due to for as a consequence of Exam attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes No. 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 \square Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred iniury 5 Pending Natural within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗌 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year, who completed cause of death (Item 23a) (Type, Print) Name and address of persp 5 filed (Month, Day, Year, 82. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - <u>2011</u> Physician/ Shifflett Wayne David 3:26 April 18. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Center Towson . Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours (Month, Day, 55 Director 213-62-9129 Maryland 1955 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 Tes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 21222 USA 4132 Eder Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Structural Worker 12 years Coast Gaurd Yard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F should be James Shifflett Mary Forbes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a cant: If item 27 is Tina Shifflett 4132 Eder Road, Dundalk, Maryland wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot April 22, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 2011 Signature of Juperal Service Licenses ^{22, Name and Address of Facility} Connelly Funeral Home Of Dundalk,P.A. 7110 Sollers Point Road, Dundalk,Md. 21222 23a. Part 1 Enter the disease, or complications may caused book, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Physician/ disease or condition resulting in death) GUIOBLASTOME MONTHS MULTIFORME Medical Due to (or as a consequence of) Examiner Edge Hally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death continuate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 🗌 Yes ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗆 No Other: |요 HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner & Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 Accident 2 🔲 No Investigation within 24 hours after death

To the Funeral Director: / Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 046360 and address of person who completed cause of death (Item 23a) (Type, Print) HARRES STREET BALTIMORD MO 21204 11CHAGE 31. Date filed (Month, Day, Registrar's Signature State

✓ DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar			Certificate of I		Reg. No	<u>CUII</u>	1287
ian	1. Decedent's Name (First, Middle,	Schult	Z			ate of Death onth Da	8 2011	3. Time of Deat
iner	4a. Facility Name (If not institution,				r Location of Death	40	c. County of Death	1
l r	Johns Hopkins Bay		(In yrs. last birt	Hoday) If Under 1 Year Months Days	If Under 24 Hrs. 8. D Hours Min. (A	ate of Birth fonth, Day, Year) -4-1922	Cou	nplace (State or Fore Intry)
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Lir
호		ALTIMORE	100. Oity, 10W		EDALE			1 ☐ Yes 2X
irec	10e. Street and Number			10f. Zip-Code		10g. Cit	tizen of What Cou	untry?
la	7526 PHILADEI				21237		U.S.	
by Funeral Director	11. Marital Status 1X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Education Armed Forces? 1 Yes, Give Year or Dates:		13. Was Decedent of F If Yes, specify Cuba 1 ☐ Yes 2 ▼No	lispanic Origin? (Specify Y an, Mexican, Puerto Rican Specify:	res or No- , etc.)	14. Race - Amer Black, White Specify: W	
Completed	15. Decedent's (Specify only highest		16a.	Decedent's Usual Occup (Give kind of work done	during most of working	16b. l	Kind of Business/l	Industry
I d	Elementary/Secondary (0-12)	College (1-4 or 5-	+)	HOMEMA	,		OWN	HOME
Be Co	17. Father's Name (First, Middle, La	ast)			18. Mother's Name (First	st, Middle, Maide		
P B	CHARLES	S	CHULTZ		MAGDELI	NE	(GER	METEN
	19a. Informant's Name/Relationshi MARY JUDE MCN			. Mailing Address (Street 0 2 0 7 GREET	and Number or Rural Roo NSIDE DR		or Town, State, Z	
	20a. Method of Disposition 1 XBurial 2 Cremation	3 ☐ Removal from State	cemete	f Disposition (Name of ry, crematory or other place			ocation - City or	
	4 ☐ Donation 5 ☐ Other (Special Service Licenses)		GARDE	NS OF FAI			ALTIMOR	
2	21 digitaldie pi i difera Cervice Ex	3	$\overline{}$		ess of FacilityCVACH SACO AVE		ALE FUN ALE, MD	
al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last	с	consequence					
1.0		d23c. If yes, outcome of			ey	0.20	23d. Date of del Month	ivery Day Year
hysician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknowr	1 Live birth 4 Pregnant at t 9 Unknown		5 Other (specify)				
by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 M No 9 Unknown Part II. Other significant condition	4 ☐ Pregnant at t 9 ☐ Unknown	time of death		iven in Part I.		o use contribute to 2 □ No 3 □ Pro	o the cause of death
by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 M No 9 Unknown Part II. Other significant condition	4 ☐ Pregnant at t 9 ☐ Unknown	time of death		silve		2 No 3 Pro	
Be Completed by Physician/M	25. Was case referred to medical examiner?	4 Pregnant at to 9 Unknown	it not resulting	in the underlying cause g	26. Place of Death (Che	1 Yes 24a. Was an autopsy performed? 1 Yes 2 AN	2 No 3 Production Production 24b. Were au prior to death? 1 Yes	obably 4 M Unkn utopsy findings avail completion of cause 2 No
To Be Completed by Physician/M	hyperfen in the significant condition in the	4 Pregnant at 1 9 Unknown ns contributing to death bu Whospital: 1 Inpatier 28a. Date of Injun (Month, Day	it not resulting if	in the underlying cause g	26. Place of Death (Che	1 Yes 24a. Was an autopsy performed? 1 Yes 2 AN	2 No 3 Production Production Specific S	obably 4 M Unkn utopsy findings avail completion of cause 2 No
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Certification: To Be Completed by Physician/M	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investige 2 Accident 3 Suicide 6 Could not determin 29a. Certifier 1 Certifying	Hospital: 1 Inpatier 28a. Date of Injury (Month, Day)	it not resulting in the control of t	in the underlying cause g A Cart C Introduct C Introdu	26. Place of Death (Che ier: 4 \sum Nursing Home ry at k? Yes 2 \sum No 28f. L me, date and place, and of	1 Yes 24a. Was an autopsy performed? 1 Yes 2 No eck only one) 5 Residence Describe how injuited a control of the cause of the caus	2 No 3 Production of the state	obably 4 Number, s stated.
To Be Completed by Physician/M	25. Was case referred to medical examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending investige 2 Accident 3 Suicide 6 Could not determined 29a. Certifier 1 Certifying (check only 2 Medical E	Hospital: 28a. Date of Injun (Month, Day) 28e. Place of Injun building, etc. 2 Physician: To the best of examiner: On the basis of	it not resulting in the control of t	in the underlying cause g	26. Place of Death (Che 1er: 4 \sum Nursing Home 1	1 Yes 24a. Was an autopsy performed? 1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 24a. Was eck only one) 5 Residence Describe how injudence to the cause of the time, date a 29d. D.	2 No 3 Proved Prior to death? 24b. Were au prior to death? 1 Yes 6 Other (Specury occurred) and Number or Rule) (s) and manner as and place, and durate signed (Month)	obably 4 Number, utopsy findings avail completion of cause 2 \(\to \) No cify) ural Route Number, s stated. e to the cause(s) h, Day, Year)
Certification: To Be Completed by Physician/M	25. Was case referred to medical examiner? 1	Hospital: 28a. Date of Injun (Month, Day) 28e. Place of Injun building, etc. 2 Physician: To the best of examiner: On the basis of	it not resulting in the control of t	in the underlying cause g	26. Place of Death (Che ier: 4 \sum Nursing Home ry at k? Yes 2 \sum No 28f. L come, date and place, and copinion, death occurred a	1 Yes 24a. Was an autopsy performed? 1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 24a. Was eck only one) 5 Residence Describe how injudence to the cause of the time, date a 29d. D.	2 No 3 Production Professional	obably 4 Number, utopsy findings avail completion of cause 2 \(\to \) No cify) ural Route Number, s stated. e to the cause(s) h, Day, Year)

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	State Registrar			artment of Heartificate of Dear	alth and Mental H	ygiene Reg. No. 0	1287
Physician/ Medical Examiner	1. Decedent's Name (First, Midden 4a. Facility Name (if not institution		Scott	4b. City. Town, or Loo	2. Date of E Month	Day Year	3. Time of Dea
Funeral Director	5. Social Security Number 220-07-1528	Horp, Hal	Age (In yrs. last birthday) 94 Yrs.	Kns Va	Under 24 Hrs. 8. Date of Elours Min. (Month, L		
faryland Ba-f show tified at	Usual Residence of Decedent 10a. State 10b. Count MD	y NA	10c. City, Town or Lo	timore			10d. Inside City L
leath with the Maryland items 23a or 28a-f sho ler must be notified at Funeral Director	10e. Street and Number 3613 Sequoi	a Ave		10f, Zip Code 212	15	10g. Citizen of What Co	
ter c	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	d If Yes, Give Year or Date	es? K No s.	If Yes, specify Cuban, № 1 ☐ Yes 2 🎇 No S		Black, White	
led within 72 hours at Hygiene. other than "natural" ent, the Medical Exe Be Completed	(Specify only high Elementary/Seconday (0-12) 12th grade	cent's Education lest grade completed) College (1-4 8yrs	or 5+) (Give	dent's Usual Occupation kind of work done durin 10 NOT use retired)	g most of working incipal	Baltimore Public Se	e County
d Mental F marked o matic even	17. Father's Name (First, Middle, James A. Sco 19a. Informant's Name/Relations	tt	· · · · · · · · · · · · · · · · · · ·		. Mother's Name (First, Middle Lena Stevenso Corlena Char		
ant of Health an	Roberta Scot 20a. Method of Disposition 1 XBurlal 2 Cremation 4 Donation 5 Other	t-Wife	3613 20b. Place of Disponsionate cemetery, creatives	Sequoia position (Name of matory or other place)	Ave, Baltin Date		1215 Town, State
Departme Importar any injur	21. Signature of Funeral Service	Licensee	2	Memorial Name and Address of ARCH, F/H	-		
ysician and he burial-transit and he burial-transit alical Examiner	23a. Part 1. Exter the disease, c shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a	as a consequence of): as a consequence of): as a consequence of):	L Intern	4	arrest,	Approximate Interval Betwee Onset and Dea Occupant
I by the attending phy stached for use as the Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2. No g ☐ Unknown		th 2 Fetal death 3 that time of death 5	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Yeai
peen signed be heta thould be deta	Part II. Other significant conditi		h but not resulting in the u	inderlying cause given in	1	tobacco use contribute to	robably 4 🔀 Unk
ertificate has been signer, page 2 should be Be Completed	25. Was case referred to medical examiner?	e Reno	1 Feylor		24a. Wa aut per 1 \subseteq Yes	opsy prior to opsy death?	topsy findings avail completion of cause 2 DNo
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the Medical Certificate: To Be Completed by Physician/Medi	1	1 M Inp 28a. Date of i (Month, i igation not be printed 28e. Place of	natient 2 ER/Outpatien njury Day, Year) 28b. Time of injury injury - At home, farm, stretc. (Specify)	28c. Injury at work? M 1 ☐ Yes	2 No 28f. Location	sidence 6 Other (Special how injury occurred (Street and Number or Ruley) (Street and State)	
in 24 hours af the Funeral Di pleted filled in Medical C	(Check 2 \(\sumeq\) Medical I	g Physician: To the best Examiner: On the basis of	of my knowledge, death of examination and/or inves	tigation, in my opinion, de	e and place, and due to the ceath occurred at the time, date	ause(s) and manner as sta	cause(s) and manner
within To the compl	29b. Signature and title of certifie	D m)	29c. License nun		the cause(s) and manner as 29d. Date signed (Month	
	30. Name and address of person	rwno completed cause o	f death (Item 23a) (Type, F	rint)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 15 Day 2011 Year 4:15 A M Charles Szollosy Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Ingleside at King Farm Montgomery 8. Date of Birth (Month, Day Year) January 30, 1924 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Days 042-44-0820 Director Hungary 87 Usual Residence of Decedent or 28a-f show 10a State items 23a or 28a-f shoner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 King Farm Blvd. # 526 20850 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Structural Engineer Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Karoly Szollosy Maria Bertok 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Szollosy / Wife King Farm Blvd. # 526 Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State 21 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place)
Montgomery Bethesda, Maryland 4 Donation 5 Other (Specify) 2011 toriúm Signatu of Foneral Service License 22. Name and Address of Facility A. Pumphrey Funeral Home, Rockville, Inc. Montgomery Avenue Rockville, Maryland 20850 Robert 300 W. MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between days Physician/ aspiration pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events years Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month Pregnant at time of death Day Year 1 Yes 2 g ed by the a detached f 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🏝 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha performed? Yes 2 No 2 🗌 No 1 Yes Division of Vital Be (25. Was case referred to medical 26. Place of Death (Check only one) assisted Hospital: Other: ပ္ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 K Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Tes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D34590 4-15-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy E. Fried, M.D. 7758 Wisconsin Avenue #211, Bethesda, Maryland 20814

OHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMonth. Physician/ 1:35 Р.м Mary Frances Stewart 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Balto. Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 X F 1 1 20 / 1926 Maryland 220-74-7866 84 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Numbe 10g. Citizen of What Country? Funeral 342 Marley Neck Rd. 21060 S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No 3altimore, Maryland 21215-6036 nan "natural", o Medical Exan 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72.1 h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiens Important: If item 27 is marked other tha any injury or other traumatic event, the I years Homemaker Self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James R. Edwards Pearl Pitts 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francine Stewart-Bacot 2821 Cunningham Dr., Baltimore, MD 21244 Page 1 and 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Crownsville Cem. 04/27/11 Crownsville, MD 21. Sign sure of Funeral Service Liverses Steph Adress Brown Jr. Funeral Home PA 140 N. Fultor Ave., Baltimore, MD 21217 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause or each line.

Immediate Cause (Final interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin sician and burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death signed by the a d be detached f g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy perform this certificate 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital 1 🗌 Yes Other: 70 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) 5 Pending work? after death. 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or inventional to the cause of examination and or inventional to t 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat) re and title of certif 2011 who completed cause of death (Item 23a) (Type, Print) 30 Name and address of person GAV 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ April Gertrude Μ. Smith 16, 8:55 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brinton Woods Sykesville Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month Day, Aug 7, 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours Min Day, Year 20 Director 218-32-8424 90 Maryland Aug Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1211 North Main Street Apt 215 21074 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. b 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Completed 3 X Widowed 4 Divorced Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Communications Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ James Madianos Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Engle Nephew 2718 Laura Drive Frederick, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 4/18/11 Hampstead, Maryland Signatule of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road a ner Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death ARTORIUSCILLOTIC Physician/ CARDIOVACULAR disease or condition 40 Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to for as a consequence on the attending physician and thed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year 1 Yes 2 4 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 https://www. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No eral Director: After this certificate filled in by the funeral director, page 2 1 No 1 Yes 25. Was case referred to redical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 1 No Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manny of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a To the Funeral C completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 3. Time of Death (0:30 f 2. Date of Death Month 1 Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Charlestown Catonsville 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral NOV. 2, Year) 921 1 ★ M 2 □ F Davs Hours Min. Marviand 214-14-7197 89 Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Baltimore 1 Yes 2 No Maryland Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral Maiden Choice Lane 21228 715 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. event, the Medical Examiner Armed Forces?

1 XYes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò 1 🛛 Never Married 2 🗌 Married ð Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural", 3 Divorced 4 Divorced Year or Dates. WW I I Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 1 and 2 should be filed within 7 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Public Servant vrs. Government Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 27 is marked r traumatic e Η. Schaefer Ι. Skipper William Tululu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 2) any injury or other tr. Lainy LeBow-Sachs / Friend 3522 Englemeade Road Baltimore, Md. 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) Entombment Dulaney Valley Mauso 4/27/2011 Timonium, Maryland 1050 YorkRoad 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson,Md.21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Denmonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last sate has been signed by the attending physician and page 2 should be detached for use as the burial-trans Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed! Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Hospital Other: 1 🔲 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 1 Natural 28d. Describe how injury occurred injury 5 \square Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Frectioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) ess of person who completed cause of death (Item 23a) (Type, Print) Maiden Choice Ln Codonsville MD 2. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2011 Physician/ Month Norma H. Tinker April 14, 2130 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Days Hours Min. (Month, Day, 1 □ M 2 🛣 F 1917 Director 202-22-2590 Pennsylvania 93 Aug Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 3681 S. Leisure World Blvd. USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Innordant: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ (unk) (unk) Emma 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 20906 | 3330 N. Leisure World Blvd. #1001 Silver Spring, MD Robert Tinker/son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 04/22/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign fore of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Witte MO1251 Reverly L. Heckrotte, P.A. Clarksville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Intracerebral Hemorrhage Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner m O Status Post Fall Sequentially list conditions. Examine Due to (or as a consequence of) cause. Enter Underlying High Blood Pressure Cause (Disease or linjury that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of): il 20 Physician/Medical Atrial Fibrillation ď Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnanc in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death g Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s performed 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Inpatient 2 - ER/Outpatient 3 - DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 🛣 No Certificate: 28d. Describe how injury occurred 04/11/11 1 Natural 2X Accident 5 Pending 11:00 A M subject fell Investigation after death Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) at home 28f. Location (Street and Number or Rural Route Number, City or Town, State) Silver Spring 3681 S Leisure World Bivd Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year,

Registrar

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State

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NORMA TINKER

Said A. Daee, M.D. 7525 Greenway Center Dr. Suite 300 Greenbelt, MD 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

1 2011

2

23044

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, 2011 Physician/ Month APRI 8 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Pecul Hoint Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, **Funeral** 1 🕱 M 2 🗆 F Months (Month, Day, Year) Director 215-18-3697 88 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified MD Harford Joppa 10e Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 610 Harborside Drive 21085 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Y Armed Forces Black, White, etc. þ 1 X Never Married 2 Married □XYes 2 □ No if Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White "natural", Completed 3 Divorced 4 Divorced WWII the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SAKALAS Baltimore, Maryland 2121 and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 8 Baker & Cook Food and Beverage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Nicholas Tsakalos Rose Markositis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 s tment of Health a George Tsakalas - Nephew 27 1600 Charlotte Ave., Baltimore, MD 21224 permit, Page 1 and 2 Department of Health Important, If item 2 any injury or other 1 once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Orthodox 4 - 21 - 11Woodlawn, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home Physician 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Dementia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury australiar as a consequence of KNOWN or Attending Physician: The law requires that the death certificate be executed after death.

Director, After this certificate has been signed by the attending physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Dame IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys Twithin 24 hours after death. To the Funeral Director, After this of Completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Jashme 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA Mayland Health Care System Hashmi 32. Reistrer's Signature 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

330

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Year

1 Lyes 2 No

Registrar

11-02902 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Crystal Tilghman 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 16, 2011 **Medical Examiner** 2019 hrs Crystal Marie Tilghman 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Wicomico Peninsula Regional Medical Center Salisbury 4 If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 7. Age (In yrs. last birthday) Funeral Months Hours Director Country) MD 213-15-2637 02/24/1973 1 M 2 XF 38 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 X No or 28a-f show other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once. Anne Arundel Glen Burnie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9th Ave. 21061 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes within 72 hours after 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 No specify. Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n injury or other traumatic event, the Medical E. College (1-4 or 5+) Veterinarian's Assistant Pet Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Franklin Mayne, Jr. Sharon A. Windsor 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Reed/Mother 10 9th Ave., Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Poplar Springs Cem. 4/20/2011 Mt. Airy, MD Donation 5 Other Specify. 21. Signature of Funeral Service License Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a Hanging Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last n and I - transit Physician/Medical AMENDED 23a, 27, 28a-f, per me, g918 8-1-11 sm X UNPENDED attending physician or use as the burial -To the Hospital or Atteoding Physician: The law requires that the death certificate be Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery Bb. Was decedent pregnant in the 1 Live birth 2 Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 🗸 Unknown / the a' 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s certificate has been signed by rector, page 2 should be detach <u>۾</u> 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other Nursing Home 5 Residence 6 Other this 1 Yes No After 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Certification: Natural fd 1940 hrs 1 Yes 2 X No subject hanged self death. Director: 5 Pending fd 4-16-11 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City Naver Town State Wicomico Dept of Corr 411 Naver Block A Por Cell 3 within 24 hours after d

To the Funeral Direct
completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X 6 Could not be Suicide determined (Specify) ce11 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Assistant Medical Examiner
32. Registrar's Sanature

30. Name and address of person who completed dause of death (Ifem 23a)

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year)

O.C.M.E.

OCME

111 Penn Street, Baltimore, MD 21201

April 17, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Aphrth 17, Daz 011 Year Christina Tarbert 9:15PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A 5513 Carter Ave Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2**X**) F Min 3/30/1920 Maryland **Director** 216-14-7045 Usual Residence of Decedent 28a-f show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland N/A 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21214 U.S.A. 5513 Carter AVe Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. ☐ Never Married 2 ☐ Married 9 Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 ★ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other the Social Security Admin Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be sent of Health and Mr.
Artant: If item 27 is r.
Ay injury or other t ပ္ Louise Klotz Nickolas Schauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11106 Cedar Lane Kingsville, Maryland 21087 Karl Schauer / Brother |11106 Cedar Lane 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 S Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/23/2011 Parkville, Maryland Moreland Mem. Park 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to for as a consequence of Exami the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and npleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 month 1 Yes 2 No 9 Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) Nursing Home Statemence 6 \(\text{Other} \) Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only 29b. Sig hature 0007128 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Suite 4105, Baltimore, MU 21204 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 19,2011 Dorothy M. Tudor 7:42A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towon Balto. If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🗓 F July 28,1928 214-24-9863 82 Yrs. Maryland Director Usual Residence of Decedent 28a-f show 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes X No Md. Balto. Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8800 Walther Blvd. Apt. 3319 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ "natural", or 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 XWidowed 4 ☐ Divorced Specify: Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James P. Gahan Genevieve M. Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. Susan Thomas 1427 Overlook Way BelAir, Md. 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place; 4-22-2011 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) Crematory 21. Signature of Funeral Service Licensee Schimunek FuneralHome 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ merics thermonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** trai Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 as . IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death the 1 ☐ Yes ∠ № 9 ☐ Unknown g Unknown signed by ti d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ paralysis, bysphasi Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cancer 24a. Was an has e 2 performed or Attending Physician: The certificate Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Nes 2 □ No Other: 4 Nursing Home 5 Residence 6 Pother (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1

Natural 5 Pending 1 Yes Fell in home evening M Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Home 6800 multer Blvd to 1 3319 Hospital 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mooth, Day,-Year)

Charles St

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:20P Dorothy Helen Trinko Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 X F Months Hours Min (Month, Day, Year 94 Wfsconsin **Director** 212-40-5660 1v 31, 1916 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Md. Balto. White Marsh 1 ☐ Yes 2 🋣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5715 Keithly Road 21162 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa If Yes, Give 1 Yes 2 No Specify: Specify: White 3 🔀 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fire Investigation Bureau 12th Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Steinbring Anna Breitzman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Trinko Son 4704 Vicky Road Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Holly Hills 4-23-2011 Middle River, Md. 21. Signature of Funeral Service Licenses 2. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 22. Name and Address of Facility 23a. Part 1. Enter We disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final erebrova Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immedia cause. Enter Underlying Due to for as a nonsequence of: Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician if for use as the burialby Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? Yes 2 N After this certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medica examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 A Residence 6 A Other (Specify) 1 ☐ Yes 2 No မ ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation hours after death uneral Director: / filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R 043580 04-18-2011 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 JUSTINE PREIS, CRNP 2300 DULANEY VALLEY ROAD 31. Date filed (Month, Day, Year)

State

Registrar

APR 21

DOROTHY

			For State Registrar	State of I	Marylanc	-	artmen <i>tificat</i> e			and M	/lental Hy	giene Reg. Na	וחי	Bushalis	12885
	Physicia		Decedent's Name (First, Middle Beatrice Unga:								2. Date of De Month Apri	eath Dav		/ear	3. Time of Death 5:50 P M
	Medi Examir		4a. Facility Name (if not institution		;)		Rock	vill			ADII	4c.	County of	Death	
	Funeral Director		5. Social Security Number 092-09-1936 Usual Residence of Decedent	6. Sex 1 \(\text{M} \) 2 \(\bar{\mathbb{X}} \) F	Age (In yrs. las 93	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Jan 11	th ay, Year) 19	18 N	9. Birthpl Count EW	ace (State or Foreign
	Maryland 28a-f show otified at	Funeral Director	10a. State 10b. Count MD Montge	,		Town or Loc								10	0d. Inside City Limits 1 ☐ Yes 2X No
	s 23a or s ust be n	eral D	10e. Street and Number 1909 Cradock S	treet			10f. Zip 209					10g. Citi USA	zen of Wh	at Count	ry?
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	d If Yes, Give Year or Dates	? No	lf 1	f Yes, spec	cify Cubar 2 X No	n, Mexican Specify:	, Puerto	cify Yes or No- Rican, etc.)		14. Race - Black, Specify:	White, e	tc.
21215-0036	within 72 ho giene. er than "na rthe Medic	Completed	15. Decedi (Specify only high Elementary/Seconday (0-12)	ent's Education lest grade completed) College (1-4 o	r 5+)	16a. Deced (Give k life. Do Purch	kind of wor O NOT use	k done d retired)	uring most	t of worki	ng	ľ	nd of Busi eral		ernment
Maryland	d be filed v Mental Hyg arked oth	To Be	17. Father's Name (First, Middle, Ocsar Schwaid	Last)	·				18. Mothe Tessi	_	e (First, Middle, EVEY	Maiden S	Surname)		
	nd 2 shoul ealth and I m 27 is m		19a. Informant's Name/Relations Louis Ungar/hus			19b. Mailin 1909	g Address Crad C	(Street a	^{nd Numbe} S tree t	r or Rura	Route Number lver Sp	er, City or i	Town, Stat , MD	e, Zip Co 209 0	ode))5
Baltimore,	Page 1 arment of H ant: If iter ury or oth	1 31	20a. Method of Disposition 1 ☐ Burial 2X Cremation 4 ☐ Donation 5 ☐ Other (n 3 ☐ Removal from Sta	te cer	ce of Dispos netery, crem 1 Jou :	natory or o	ther place	atory	_	Date /21/11		cation - Ci		
Balt	permit. Depart Import any inj		21. Signature of Funeral Service	ticensée Haute	MQ1						n Servi				
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each li	ed the death. ine.	Do not ente									Approximate Interval Between Onset and Death
8	ate be executed bhysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequer									+	
. Box 68760	ath certific attending p for use as	Me ∣	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant g Unknown	n 2 🗌 Fetal o at time of dea	death 3 🗌	Ectopic p		/			2	23d. Date of Month		y Day Year
s, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditi	ons contributing to death	but not result	ting in the ur	nderlying o	ause give	en in Part I						cause of death?
Division of Vital Records,	: The law requ cate has beer , page 2 shou	Completed by									24a. Was auto perfo 1 Yes		pric dea	or to com	sy findings available pletion of cause of
/ital	iysician: The iis certificate director, pag	To Be	25. Was case referred to medical examiner?1 ☐ Yes 2 X No	Hospital:	atient 2 🗆 EF	2/Outpotion	- 2 D DC	Other	ce of Deat			-l 0 3	7 1 011 - 4	016.1	hospice
on of \	nding Phys th. : After this : funeral di		27. Manner of Death 1 X Natural 5 □ Pendi	28a. Date of in	jury 2	8b. Time of injury		Bc. Injury work?	at	2	28d. Describe h			Specity)_	nospice
Divisio	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completed filled in by the	al Certificate:	3 Suicide 6 Could 4 Homicide detern	not be 28e. Place of Ir	njury - At hometc. (Specify)	e, farm, stre	et, factory				28f. Location (\$ City or Tox		Number c	or Rural F	Route Number,
	ne Hospital n 24 hours : ne Funeral I pleted filled	Medical	(Check 2 \(\bigcup Medical \)	g Physician: To the best of Examiner: On the basis of g Nurse Practioner: To the	examination a	nd/or investi	gation, in n	ny opinior	n, death oc	curred at	the time, date a	and place,	and due to	the caus	se(s) and manner stated
	To the I within 2 To the I comple		29b. Signature and title of certifie	miller	CR	NP	29c.	License	number 320	1		29d. Date	signed (A	Nonth, Da	ay, Year)
_	Le		30. Name and address of person Debrah Miller,	CRNP 6001 M	luncast	er Mi		l. Ro	ckvil	lle,	MD 208	<i>⊤</i> 55	7		
	Stat Registra	.0	31. Date filed (Month, Day, Year)	32. Regist	trar's Signatur	W.									

DHMH 17 Rev 7/2009

fo the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun

2 😿 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 18, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Zabiullah Ali, M.D. 111 Penn Street, Baltimore, MD 21201

31. Date filed (April, 27, Ye State Registrar

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 0 / 6:45 AM **Physician** ONA 100 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A **Baltimore** Johns Hopkins Bayview Medical Center 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F Days Hours Min 215-14-9238 87 May 8,1923 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes XXNo Director MD Edgemere Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21219 United States Funeral 2520 North Snyder Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW I ☐ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>ک</u> Specify: 3 X Widowed 4 Divorced White WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Welsh Company Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Truck Driver/Owner 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Bush John Frederick Welsh, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21219 2532 North Snyder Avenue Edgemere, MD Mrs. Carolyn Klimek (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4/19/2011 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donatio 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the shock, or hear tailure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** 0 disease or condition resulting in death) /Medical Due to (or s a consequence of) Examiner entoration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Multiple Mychuma The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the b IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: certificate has 2 🗌 No 1 🗌 Yes 2 X No or Attending Physician; 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient examiner? Other: 4 \sum Nursing Home 1 ☐ Yes 2 X No 3 DOA 2 ER/Outpatient 5 Residence 6 Other (Specify) ၉ Director: After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation (Month, Day Year) Injury 1 TYes 2 No hours after death. 2 Accident 3 🗌 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) 29b. Signature and title of/certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000

6+1V

Just 131. Date filed (Month; Day, Year)

30. Name and address of person

22. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

4940 Eastern Avenue, Baltimore, MD, 21224

Day, Year)-

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician /Medical april Washington 12.57 AM Halle 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day,) July 12, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Year) 1917 1 □ M 2 💢 F South Carolina 93 Director 220-30-2181 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits shov r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ¥ Yes 2 □ No Director Maryland N/A Baltimore death with the 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1407 Ashland Avenue 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify \$ Specify: Black 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) al Hygiene. Elementary/Secondary (0-12) Master Barber **Owner** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental is marked Charlie Pickens Lula Hunt ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trau David D. Humphries, Sr. / Son 3400 The Alameda Baltimore Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial 4 ☐ Donation 5 ☐ Other (Specify) 4/21/11 Baltimore Maryland Runeral Service Licensee 22. Name and Address of Facility LEONAY O. RUCK. Inc 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liceace or hipsi) that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physiciar Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No should be detached the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate has 2 No 2 🖪 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 \square Nursing Home 2 No 1 Inpatient 1 Tyes 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify) this 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🗍 Yes 2 🗌 No 2 Accident s after death I Director: / 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cases of death (Item 23a) (Type, Print)

HRVIND

31. Date filed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Appril 1 20^Yfa1 Williams 10:00P M Angel Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente Towson Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 12 F Months Days Hours Min. Director infant Yrs 04 . 11m MD Usual Residence of Decedent 10a. State 10b. County with the Maryland or than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No MD <u>Gwynn Oak</u> 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7102 21207 Marston Rd within 72 hours after death 11. Marjtal Status 12. Was Decedent Eyer in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married ğ If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify Completed 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) INFANT Infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ೭ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic Don, Carlos, Williams Danita, Sherie, Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greater Baltimore Med Ctr 6701 N. Charles Street Baltimore, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🖫 Other (Specify) in state 21. Signal are of Fund al Service Licensee Ronald S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ Prematurity treme 37min Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital 1 🗌 Yes Other: မ 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🗹 Natural (Month, Day, Year) injury 5 Pending Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completed filled in by the f Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifie 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address

31. Date filed (Month, Day,

Division of Vital Records, P.O. Box 68760

21215-0036

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Rel

Sut 14 Lutherville

on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

205

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 00p M Deborah Ward 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FRANKLIN SQUARE Rosedale Baltimore Haspita Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Month, Day, Ye January 1, 1 □ M 2**X** F Months Days Hours Min 63 Director Mary Land 217-54-2953 1948 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Sparrows Point 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4633 Green Cove Circle 21219 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 XMarried 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. ģ Baltimore, Maryland 21215-0036 Debora 1 ☐ Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home <u>12 years</u> Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i once. Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellis Gainer Bertha Corley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4633 Green Cove Circle, Sparrows Point, MD. 21219 William Ward Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aprilate18, 1 XBurial 2 Cremation 3 Removal from State Crest Lawn Cemetery 4 Donation 5 Other (Specify) Marriottsville, MD. 2011 nature of Juneral Service Licens 22 Name and Address of Facility Lome Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk,MD. 21222 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ HY POXIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner cancer Lung Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day ate has been signed by the a page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Certificate: To Be Completed 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 061907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRChukwuma m. Ebo 9000 FRANKLIN SQUAREOR Balto ind 21237 31. Date filed (Month, Day, Year) - . . State

✓ DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month $20\overset{\text{Year}}{1}$ Allen Ralph Warehime pril 5:45A Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sykesville Carroll Brinton Woods Health Care 8. Date of Birth
(Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1**x x**M 2 □ F Min. Days Country) Maryland 64 218-44-1734 **Director** 1946 Dec. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Carroll Sykesville 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 21784 1442 Buckhorn Road United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 X Divorced Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10th Disabled n/a permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ralph Y. Warehime S. Doris Morin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9204 Bengal Road Randallstown, MD 21133 S. Doris Warehime mother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Lake View Mem: Park April 2011 Sykesville 4 ☐ Conation 5 ☐ Other (Specify) Purrier-Queen Funeral Home & Crematory PA 1912 W. Old Liberty Road Sykesville, MD 21784 21. Sign Funeral Service Dicense Linu Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause Ent. Indulying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir and -transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for I in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CARDIOVASCUCAR Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 1 No certificate Yes 2 No ours after death. eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 No Other: ၉ 1 🗀 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Hospital within 24 hours To the Funeral Medical 29a. Certifier 🗹 Certifying Physician: To the best of psyknowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number 20806 ucoscu) 204 and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Date filed

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charlotte Jean Wood Examiner Charlotte Jean Wood Charlotte J	d. Inside City Lim 1 Yes 2 Y
Rock Spring Village Funeral Director Forest Hill S. Soolal Security Number: 1. S. Soolal	y) d. Inside City Lim 1 □ Yes 2 1 1 y? n Indian, c.
227-18-0142 Substitution Substi	y) d. Inside City Lim 1 □ Yes 2 1 1 y? n Indian, c.
10a. State 10b. County 10c. City, Town or Location 10d. Top Code 10g. Citizen of What Country 21050 2105	1 □ Yes 2 2 1 1 y? y? n Indian, c.
17. Father's Name (First, Middle, Last) Bruce H. Slaven 19a. Informant's Name/Relationship (Type, Print) Bonnie Ramirez – Daughter 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20a. Method of Disposition 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Crematory) At lantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySchimunek Funeral Home of Crematory 22. Name and Address of FacilitySchimunek Funeral Home of Crematory 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 25c. Location - City or Town. State. Zip Co. Deathor (Specify) 26. Place of Disposition (Name of Crematory) At lantic Crematory 27c. Name and Address of FacilitySchimunek Funeral Home of Crematory 28d. Place of Disposition (Name of Crematory) 29d. Place of Disposition (Name of Crematory) At lantic Crematory 29d. Place of Disposition (Name of Crematory) At lantic Crematory 29d. Place of Disposition (Name of Crematory) At lantic Crematory 21. Signature of Funeral Service Licensee 22a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interded the Company of Crematory 20d. Place of Disposition (Name of Crematory) At lantic Crematory 22a. Name and Address of FacilitySchimunek Funeral Home of Crematory 22a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interded the Crematory 22a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interded the Crematory 25c. Place of Disposition 26c. Place of Disposition 26c. Place of Disposition 27c. Place of Disposition 27c. Place of Disposition 27c. Place o	n Indian, c. ⊇
17. Father's Name (First, Middle, Last) Bruce H. Slaven 19a. Informant's Name/Relationship (Type, Print) Bonnie Ramirez – Daughter 19a. Method of Disposition 19a. Method of Disposition 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. Place of Disposition (Name of Cemellor), crematory of other place) 20a. Method of Disposition 1 Burial 2 (Dremation 3 (Pemoval from State) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySchimunek Funeral Home of Cemellory, crematory of the place of Disposition (Name of Cemellory, crematory) 22. Name and Address of FacilitySchimunek Funeral Home of All W. MacPhail Rd Bel Air, MD 21014 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	c. 2
17. Father's Name (First, Middle, Last) Bruce H. Slaven 19a. Informant's Name/Relationship (Type, Print) Bonnie Ramirez – Daughter 19a. Method of Disposition 19a. Method of Disposition 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. Place of Disposition (Name of Cemellor), crematory of other place) 20a. Method of Disposition 1 Burial 2 (Dremation 3 (Pemoval from State) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySchimunek Funeral Home of Cemellory, crematory of the place of Disposition (Name of Cemellory, crematory) 22. Name and Address of FacilitySchimunek Funeral Home of All W. MacPhail Rd Bel Air, MD 21014 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	stry
21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySchimunek Funeral Home of 10 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the disease or condition resulting in death) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the disease or condition resulting in death) 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the disease or condition resulting in death) 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the disease or condition resulting in death) 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the disease or condition resulting in death) 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the disease or condition and disease or condition resulting in death) 25b. Due to (or as a consequence of): 26c. Due to (or as a consequence of):	
22. Name and Address of FacilitySchimunek Funeral Home of the MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the mode of dying and the death. In the mode of dying are shock, or heart failure. List only one cause on each line. Physician / Medical Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the disease or condition in the cause on each line. Physician (Medical Examiner) Sequentially list conditions, if any, leading to immediate in the mode of dying, such as cardiac or respiratory arrest, in the cause of the c	61 n, State
Physician /Medical Examiner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the disease or condition resulting in death) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the disease or condition or each line. Due to (or as a consequence of): Due to (or as a consequence of):	of Bel A
The past 12 months?	Onset and Death
를 수를 X 9 Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the contributions of the underlying cause given in Part I. 1 Yes 2 No 3 Probable and the underlying cause given in Part I.	
0 L (1)	y findings availal pletion of cause o
examiner? Second of Death Check only one Check one	isted Living
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day)	
Daved 5 Du D32299 Dpn.1 18 20	nd.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The part of the second secon	ed. ne cause(s)

amend #3 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 16 Day 2. Date of Death Physician/ Month Blanche WICKS 9:40 PM Medical APril 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore N/ASocial Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🔀 Hours 0270471920 Mary land Director 213-14-8883 91 Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No MD N/ABaltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 3513 West_Franklin Street 21229 items U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ٥ 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 "natural", 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Black Health and Mental Hygiene. tem 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Johns Hopkins (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Hospital Nurse Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Reynolds Bernice Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Wicks(son) 9217 Turnbull Rd., Randallstown, MD 21133 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 04/22/11 Owings Mills, MD 21. Signature of Funeral Service Licensee Joseph Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death rhmediate Cause (Final disease or condition resulting in death) Ord-Stage Dementia Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year 1 Yes 2 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law certificate has page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To the Hospital or constitution of the Funeral Director After this cereated filled in by the funeral director. 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

MSRIGHT WHILM D 29c. License numbe 29d. Date signed (Month, Day, Year) D0057463 4/17/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N S. Rajapakse, M.D 2835 Smith AV 5-203 Baltimore, MO. 21209. 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** awrence /Medical on 4a. Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) Country, Feb. 28,1945 Maryland If Under 1 Year | If Under 24 Hrs.

Months Davs Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Months Days 1 ★ M 2 □ F 217-40-3713 Director 66 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 1x No MD Baltimore Dunda1k 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 8518 Kavanagh Road Funeral 21222 United States Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 <u>ک</u> 1 ☐ Yes 2√ No Specify 3 Widowed 4 Divorced Specify. White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical Elementary/Secondary (0-12) College (1-4 or 5+) 6 Years <u>Night Watchman</u> City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Zarro, Sr. Doris Virginia Rowland ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Margaret D. Zarro/Wife 8518 Kavanagh Road Dundalk, Maryland 21222 permit. Pages 1 and 1 Department of Health Important: If item 27 any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 4 Donation 51 Other (Specify) Oak Lawn Cemetery 4/21/2011 Baltimore, Maryland ure of 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Sign obral Service Licens 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) respiratory 77Medical Due tr (or as a consequence of) Examiner Due to ar as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed and as the burial-tra resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 🗌 Ectopic pregnancy Live birth 2 Fetal death Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital 2 No 1 Tes 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation Injury death. 2 🗆 No 1 Yes Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) ו 24 hours פ Funeral I Hospital

State Registrar

within 2

29a. Certifier

(check only one)

29b. Signature and title of confifier

Haitham 31. Date filed (Month, Day, Year) APR 2 1 2011 32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month. Dav. Year)

600 North Wolfe St, Baltimore, MD, 21287

16,201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 7 per fh e914 4-26-11 yt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Zabchin Physician/ Month 50089e 6:30 P Medical April 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles Genesis Nursing Home Waldorf Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania **Funeral** 8. Date of Birth Months Days Hours (Month, Day, Year) ept 22, 1925 156 16 9152 **Director** 85 Sept Usual Residence of Decedent Show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits MDCharles Waldorf 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13486 Holly Spring Drive 20601 United States Was Decedent of Hispánic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💯 No Specify White 3 X Widowed 4 □ Divorced Specify: Year or Dates. WIII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Mea Elementary/Seconday (0-12) College (1-4 or 5+) 12 State Farm Insurance Insurance Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Capeton Zabchin Mary Poliniak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4148 Chastain Drive, Melborne, Florida 32940 Kathy Lembouse (Daughter) 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 4 ☐ Opnation 5 ☐ Other (Specify) Maryland Veterans Cemetery April 25, 2011 Cheltenham, MD Signature of Funeral Service Lice 22. Name and Address of Facility Lee Funeral HOme, Inc 6633 Old Alexandria mo15 Clinton, MD 20735 Ferry Road. 23a. Part. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Failure Physician/ Congentive disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day signed by the a Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by thrombosis within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Trupes t 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 No 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 No Other: ဂ္ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 1 A-Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie D71199 04/19/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive it, Annapolis, mp. 21401 31. Date filed (Month, Day, Yea State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 04 2017 1:55 D M Zebron Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Citizens Care Center Harford <u>Havre De Grace</u> Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 24 Hrs. 8. Date of Birth 1 🗆 M 2 🗶 F Hours Min 07/07/1929 212-28-3186 **Director** 81 MD Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 X No Harford Pylesville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11 Constitution Road 21132 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 Yes : 2 🛛 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home <u>Home Maker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev George Hoffman Margaret Bohmlein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Zebron, Husband <u> 11 Constitution Road, Pylesville, MD 21132</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Gardens Of Faith 04/19/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Physician: The law requires that the death certificate be executed ician and burial-tran resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 mg Month Year Day Pregnant at time of death Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page performe 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred t dedica Be 26. Place of Deat (Check only one) examiner? Hospital 2 No ျ 1 🗆 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man r of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated e and title of certifie 29d. Date signed (Month, Day, Year) 18/11 ss of person who completed cause of death (Item 23a) (Type, Print Mn ewis un-Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 419 Ashlock PM Medical 18 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Square FRANKLIN Hospital Baltimore Rosedale 7. Age (In yrs. last birthday) **87** Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 - 27 - 192-3 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Director show permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 □ No 10f. Zip Code 10g. Citizen of What Country Funeral 21213 US A 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ò 1 Never Married 2 Married Yes 2 No 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates. 3 Divorced Completed Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sel Femployed Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ASHLOCK Known 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashbock - Wife Essie 1319 N. Kenwood Are. Balto, MO 21213 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD Nationa -26-2011 aurel. 21. Signature of Juneral Pervice Licensee 22. Name and Address of Facility 1101 E. North Ave. March Spent Mille Baltimore MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Preumonia days Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Tes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Certificate: To 1 Tes 1 Inpatient 2 Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed Month, Day, Year) MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. STeele 21237 DR Laura 9000 Franklin Square DR. Balto md 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death .Day 2011 Physician/ April William b. Anacker 13, 3:00 AM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Envoy of Pikesville Pikesville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Hours 1 🕅 M 2 🗆 F Dec Pay, Year 17 Mary Yand Director 93 214-03-7634 Usual Residence of Decedent show ms 23a or 28a-f shor must be notified at 10a, State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Freeland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21053 USA 21305 Heathcote Road items death 12. Was Decedent Ever in U.S. Armed Forces?

1 ₭ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Medical Examiner Black, White, etc. ō ş 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white "natural" Completed 3 X Widowed 4 Divorced WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the O 12 arborist agriculture Be filed 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) 12 should be file lith and Mental H 27 is marked o r traumatic eve ပ William Frederick Anacker Lillian Barnes Fruit. Page 1 and 2 should be at artment of Health and Men trortant. If item 27 is marke by injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21208 19a. Informant's Name/Relationship (Type, Print) Matthew Anacker/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🐰 Donation 5 ☐ Other (Specify) cemetery, crematory or other place) permit Det ar Impor any in once. State and Addreson Faciliboard 655 W. Baltimore Street Dixector 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause or Immediate Cause (Final Interval Between care Onset and Death Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir ospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Month Pregnant at time of death Day Year the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? performed' certificate Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 🗌 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in Medical uneral Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 2 Certifying Nurse Practioner To the best of my knowledge, death acc ed at the time, date and place, and due to the cause(s) and manner as stat 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CRNP R080210

Statu Registrar 30. Name and addres

lorth Charles St

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month M 5:45 AM Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arunde Annapol 7. Age (In yrs. last birthday) 8. Date of Birth If Under 1 Year 9. Birthplace (State or Foreign Country)
Greece **Funeral** 1 - M 2 AF 89 Months Days Min. Year) 1921 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Anne Arundel Annapolis 1 Yes 2x XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 35 Milkshake Lane 21403 HSA Was Deceue... Armed Forces? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married white If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify: Completed 3xxWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hairdresser Beauty ed other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental F marked o ည Mark Stamoulis Mary Zisoulas and ∧ is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter P. Budulas/ Son 15817 Haynes Road, Laurel, MD 20707 other! 20a. Method of Disposition Department of H Important: If ite any injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State April 27, Fernwood Cemetery 4 Donation 5 Other (Specify) 2011 Lansdowne, PA 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityDonaldson Funeral Home, P.A. J. Ken Skila M01053 313 Talbott Ave., Laurel, MD 20707 23a. Int 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiamin disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy signed by the atter ☐ Pregnant at time of death☐ Unknown 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ → 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv 1 ☐ Yes 2 ☐ No Yes 2 DN To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 90 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending iniury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and of certifier 4/20/2011 037036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) isomal Drive Cholenno 21619 2118 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month G 2011 RGINIA 355 4a. Facility Name (if not institution, give street and number) 4c. County of Death Tate House Linthicum Anne Arundel 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗹 F Months Days Hours Min. June 25, Year 1920 Maryland 90 212-07-9728 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Howard Elkridge 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6391 Rowanberry Dr., Apt. 211 21075 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 K Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Collins Margaret Spearman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 219 Chelsea Rd., Pasadena, MD 21122 Pat Jeffers (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment Loudon Park Cemetery 4/26/11 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Put Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onser and Death Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Oth Hospital: DICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1. Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation

Examiner physician and s the burial-transit Box 68760 signed by the a d be detached f P.O.

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show notified at

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r than "natural", or items 23a or the Medical Examiner must be

and Mental Hygiene.

permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, it

Physician/ Medical

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examin

Physician/Medical

Completed by

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Certificate:

Medical

29a. Certifier

only one 29b. Signature and title of cer

Name and address of person

31. Date filed (Month, Day, Year) APR 2 2 201

6 Could not be

determined

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MD

Hospital or Attending Physician: The law requires that the death certificate be executed Records, cate has been sig ; page 2 should b Division of Vital tor: After this certific the funeral director, filled in by сотретер

24 hours after death. Funeral Director: A To the Within 2.

> State Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) (Type, Print)

EN 32. Registrar's Signatur

Q

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Barksdale Sherman 11:30 A M 2011 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Northwest Seasons Hospice Randallstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Hours (Month, Day, Ye Director 72 216-34-2508 Usual Residence of Decedent Show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director MD NA Baltimore 28a-f XXYes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ntal Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be 1 Funeral 21218 USA 1542 Northgate Road filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indiar Armed Forces? Black, White, etc. African þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: American 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10th Grade Batch Maker D.A.P. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည Starks Emory Oliver Archie Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1542 Northgate Road Baltimore, MD 21218 Janet E. Barksdale-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State King Mem. Pk. 1 X Burial 2 Cremation 3 Removal from State 04-20-11 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Juneral Service Licensee 22. Name and Address of Facility 1206 West North Avenue William C. Brown Community Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ES CVA disease or condition Medical resulting in death) **Examiner** AThenschentic Cardionstular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Undergood or light Due to (or as a consequence or) Examin Cause (Disease or iinjury that initiated events -tran resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsv death? certificate 1 ☐ Yes 2 ☐ No Yes 2 Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 T 100 Other: 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral I

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Misky apathlm. D. 4/15/11 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ariation BIVD-GLEN Bumbe.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 20 ay 2011 Physician/ 0040 Harlan William Bryant Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Elkton Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**3€34**M 2 □ F Months Hours 03/29/1922 West Virginia 89 Director <u>235–50–8682</u> Usual Residence of Decedent 10d. Inside City Limits shov 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 468 W. BelAir Avenue 21001 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ğ 1

✓ Never Married 2

✓ Married Yes 2 XNo 21215-0036 1 Yes 2XXNo Specify Specify: White If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) th and Mental Hygiene.
77 is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Visabled Disabled Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Health and Mental Himportant: If item 27 is marked ott any injury or other transmone. Tina Sharp Μ. Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 614 Webb St., Aberdeen, MD 21001 Velda Mace (sister) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Mill Point, WV 4 ☐ Donation 5 ☐ Other (Specify) Sharp Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 art 1. Enter the disease, or com a tations that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ 050,000 Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine attending physician and for use as the burial-trar that initiated events resulting in death) Last Physician/Medical • Hospital or Attending Physician; The law requires that the death certificate be . 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy page 2 performed En en 2 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗖 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Descripting Projections: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and minimal as attacks.

 Descripting Projections: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

APR 2 2 2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Registrar

DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

William Tan,
31. Date filed (Month, Day, Year)

1645 Liberty Road

32. Registrar's Signature

D34849

Eldersburg, MD

21784

April 21, 2011

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	Physicia	ın/	Decedent's Name (First, Middle, Last) DORIS			_	OHANNET	T	2. Date of De	ath 2 Day	20 ° 1	3. Time of Death
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			FOREST HILL HEALT					REST HIL	_		HARF	ORD
	Funeral Director		5. Social Security Number 6. Sex 1	M 2 🔀 F	e (In yrs. Ia 84	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 07/29/1	th 926		place (State or Foreign nsylvania
	how at	'n	Usual Residence of Decedent 10a. State 10b. County			, Town or Lo	cation					10d. Inside City Limits
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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 603 N. Stuart Street	a+			10f. Zip Code	221	- 1	10g. Citizen		ntry?
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Baltimore, Maryland 21215-0036	e 1 and of Hea If item ir othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Re		20b. Pl	ace of Dispo	sition (Name of patory or other place	1	Date		on - City or To	
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	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):						
Dto	nia e		that initiated events c. resulting in death) Last	Due to (or as	conseque	ence of):						
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Box 6876	eath certificate b attending physic i for use as the b	Completed by Physician/Medic	200. Was deceder pregnant	c. If yes, outcome	of pregnan	ncy	Ectopic pregnanc			23d. I	Date of delive	ery
	death the atte	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a	t time of de	eath 5	Other (specify)			1	Month	Day Year
P.O.	requires that the de been signed by the should be detached	y Ph	Part II. Other significant conditions conti	ibuting to death b	ut not resu	ılting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use co	ontribute to th	he cause of death?
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al R	Physician: The law this certificate has al director, page 2 s	Be Co	25. Was case referred to medical				26. PI	ace of Death (Chec	1 🗌 Yes		1 🗌 Yes	2 🗀 No
Vit	hysici this ce	욘	T L res 2 LNNo			ER/Outpatien	t 3 □ DOA Othe	er: 4 Nursing H	ome 5 Resid	lence 6 🗆 O	ther (Specify)
Division of Vital Records, P.O.	ttending P death. tor: After t the funera	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Day	ry r, Year)	28b. Time of injury	28c. Injury work	y at	28d. Describe h	ow injury occi	urred	
visio	r Atter ter dea irector irector	ertifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubul	ry - At hor (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tow		nber or Rural	Route Number,
Ö	Hospital or Attending Physician; The law requires that the death certificate I 24 hours after death. Funeral Director: After this certificate has been signed by the attending physeted filled in by the funeral director, page 2 should be detached for use as the		29a. Certifler 1 Certifying Physici				ccured at the time	, date and place, a			nner as state	ed.
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th	Medical	(Check 2 ☐ Medical Examiner only one) 3 ☐ Certifying Nurse F	: On the basis of e	camination	and/or investi	gation, in my opinio	on, death occurred a	at the time, date a	nd place, and o	due to the car	use(s) and manner stated.
	Voit To 1		29b. Signature and title of certifier				29c. License	225)		29d. Date sigr		,
	2		30. Name and address of person who com	pleted cause of de	eath (Item :	23a) (Type, P				april	22,2	//
	0		DAVID DUNN 615 31. Date filed (Morth, Day, Year)	W. MACE			BEL	AIR, MD.	21014			
	Stat Registra		APR 2 2 201	OZ.	. o oignatt	The same of the	W.S					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Collin Carrington Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death More NA Gener 8. Date of Birth Social Security Number yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Hours (Month 122-38-4761 nth, Day, Year 66 Director Usual Residence of Decedent 10a. State at 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified MD NA Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3939 21215 Penhurst Avenue USA ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American India Black, White, etc. African Completed by 1 ☐ Yes 2 🔀 No If Yes, Give 1 X Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced American Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

11nk. 16b. Kind of Business Industry unk. 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) unk. 12th Grade <u>2vrs</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. unk. ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Commodore Drive Essex, MD 21221 Emily Robinson-Friend 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 04 - 22 - 11Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Que to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Other: ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☑ Natural iniury 5 Pending work? 2 No Accident
Suicide Investigation 24 hours after deatl npleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) MDne and address of 23a) (Type, Print) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 14, Da 2011 Troy 11:00 p.M Thomas Coiner. Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bethesda Health & Rehabilitation Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 6. Sex 8. Date of Birth Days Hours Aug 26, Year 942 TXEXM 2 68 **Director** 579-52-3043 Pennsylvania Usual Residence of Decedent Show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f shor ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5721 Grosvenor Lane 20814 United States 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Specify: Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Estimator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva Kathleen Kulpcavage Thomas Troy Coiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5834 Lake Wylie Rd. Clover, South Carolina 29710 Margaret B. Clem (sister) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Aprilate 21, permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Beltsville, MD. 2011 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Some us of fune 13 rvice Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ HEART CONGESTI Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of cause. Enter Underlying the Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? After this certificate 1 Yes 2 KNo Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 PNo Hospital Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral or 27. Manner of Death 1 Natural Certificate: 28a. Date of injury 28b Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, usain occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Car Burg and 00057124 4115111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Dr. Rockville, Maryland 20850 Truong Bao, M.D. 32. Registrar's signature State Registrar

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 2011 Year **Physician** 14, 9:04 AM M April Stephen E. Crane /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 21426 Greenbrier Road Boonsboro Washington 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday, 6. Sex **Funeral** Months Days Hours Min. California 1 🕅 M 2 🗆 F Ĩ936| 549-48-0567 74 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Everning must be inclined at 1 ☐Yes 2 ☑ No Director MD Washington Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 77 Manor Drive #102 Funeral within 72 hours after death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mar Elementary/Secondary (0-12) College (1-4or 5+) construction 9 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Harvey Crane Roberta Elaine Lawrence ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21426 Greenbrier Road Boonsboro, MD Rita Crane/spouse 21713 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servi sicensee wade 28 Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, one art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic DlosWacheL Dumonary **#**Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed and Due to (or as a consequence of): burial-Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nypertension autopsy perform After this certificate 1 ☐Yes 2 ☐No 1 □ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 20 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IN Bui MD 1138 Opal CT Hase 1138 Hagerstown, MO 21740 31. Date filed (Month, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fb 2916 6-16-11 byt State of Maryland Department of Health and Mental Hygiene ()

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2011 March 1:42 PM Constance Chatard /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 12237 Garrison Forest Rd. Owings Mills 5. Social Security Number 3202 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday) Months Days 1 □ M 2 😾 F 213-48-3702 virginia Director 95 Sept 16, 1915 Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantmer must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Director MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 USA 12237 Garrison Forest Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Moncure Nelson Lyon Constance Bentley ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juliana Alexander/daughter 607 Piccadilly Road Towson, MD21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral S. vice Licer 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Wale Director 21201 Baltimore, MD Enter the disease, or complications that caused the death. or heart failure. List only one cause on each line. Do not enter the mody of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conse dence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year 5 Other (specify) detached 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 st 24a. Was an autopsy performe 1 ☐ Yes 2 🔼 No 2 🗌 No or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death.

leral Director: Al
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or nestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31. Date filed (Mo State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #196 Per Ana BD G915 5/02/2011 JH
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Mary A. Carpenter 7:40 PM^M 10, 2011 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 402 Park Avenue Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 31, 9. Birthplace (State or Foreign Country) Indiana Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Year) 1918 1 □ M 2 🔯 F 93 261-46-0163 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Examiner is ust by notified at Director 1 ☐ Yes 2 ☐ No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 Park Avenue 21801 USA by Funeral filed within 72 hours after death Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 should be filed whand Mental Hygie is marked other t nurse healthcare event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jonathan Edward Comer Ethel Landers ပ 19b Nailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
D_partment of Health ar
Important: If item 27 is
any injury or other trau Suzanne McKeen/daughter B Park Avenue Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □Other (Specify) 21. Signature of Funeral Serv State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

23a. Part Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau Final **Physician** disease or condition resulting in death) ASWD /Medical Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) o. signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Nesidence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Injury 1 ☐Yes 2 ☐No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) busha Nathan April 13/5 DR. USHA NATESAN D051359 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATESAN, 1415. S. DIVISION DR. USHA ST, SALISBURY, MD 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please	Type or Print in Black indelible ink. Ensure All Copies Are L	_egible	1	1 0	_
	State of Maryland / Department of Health and Mental Hygiene	201		12	9
	Contificate of Dooth				

		Registrar	Certii	ricate of	Deam			Reg. No.	
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) Ja son Rober	t Dunker	ly			2. Date of De Month April 18,	Day Year	3. Time of Death 2315 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital Baltimore					4c. County of Deatl	1	
Funeral Director		5. Social Security Number 214-23-9355 6. Sex	7. Age (In yrs. last		If Under 1 Yes		24Hrs. 8. Date of B	Birth(MM/DD/YYYY) 9. Bir h11,1984 Co	thplace (State or gn untry)MD
Maryland 28a-f sbow any d at once,	tor	Usual Residence of Decedent 10a. State		wn or Location					10d. Inside City Limits 1 Yes 2 No
i with the Maryland ms 23a or 28a-f sho be notified at once.	Director	1808 Queen Anne S	Square		10f. Zip Code 21	015		10g. Citizen of What Cou USA	ntry?
r death or ite	by Funeral	1 X Never Married 2 Married Arm 1 3 Widowed 4 Divorced If Yes, Girl Pates		If Ye	s, specify Cuba Yes 2 X No	n, Mexican, P specify:	n? (Specify Yes or N Puerto Rican, etc.)	White, etc.	ican Indian, Black, Thite
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed I	12th	ege (1-4 or 5+)	during mo:	s Usual Occupa st of working life enter	e. DO NOT us		16b. Kind of Business/	
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than nette event, the Medica	Be	17. Father's Name (First, Middle, Last) William R. Dunker				Li	Name (First, Middle Inda Joh	nson	
MD 2 d 2 should lth and M n 27 is m	T ₀	19a. Informant's Name/Relationship (Type, Print Linda Dunkerly /n	nother	1808	Queer	Anne	e Square	mber, City or Town, State Belair MD	21015
Baltimore, MD 21215. permit. Pages I and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked of unjury or other traumatic event, the		20a. Method of Disposition 1 Burial 2 Cremation 3 Remo 4 Donation 5 Other Specify:	val from State cren	natory or othe	on (Name of ce or place) emoria	1	Date 4/22/11	20c. Location - City or Belair M	·
Balti permit. Departn Import		21. Signature of Funeral Service/Licensee	nelfh		me and Address	v Fur	neral Ho	e Ave. Bal me of Esse	
Physician /Medical ixaminer		23a. Part I. Enter the disease, or comblications t failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple	V	not enter the	mode of dying,	such as card	diac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and Death
ZAMINICI		or condition resulting in death) Due to (or Sequentially list conditions,	r as a consequence of):						
	Examiner	if any, leading to immediate Due to (or cause. Enter Underlying Cause Unsease or injury that initiated	r as a consequence of):						
kecuted nand - transit		d.	. ,						
18760, tificate be ex ng physician as the burial		IF FEMALE: 23c. If	yes, outcome of pregnance	-			.	23d. Date of delivery	
Box 687 he death certific	Physician	past 12 months?	ive birth Pregnant at time of death Jinknown	2 Feta 5 Othe	death 3 r (S <i>pecify)</i>	Ectopic pr	regnancy	Month D	ay Year
s, P.O. Lires that the signed by the detache	ē	Part II. Other significant conditions contribut	ing to death but not result	ting in the und	derlying cause o	given in Part I		tobacco use contribute to the second	
Division of Vital Records, P.O. Box 68760, the Hopital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Piners of the Rineral Director: After this certificate has been signed by the attending physician and optietely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Completed								topsy findings available completion of cause of
tal Recian: The certificate ector, page	Be	25. Was case referred to medical examiner?				O#5 = = =	heck only one)		
Pysi	၉	1 Yes 2 No						Residence 6 Other	
Division of tall or Attending Is after death. al Director: After led in by the funer	ation:	2 Accident Investigation	Month Day Year) 18, 2011 20	b. Time of Inju 115 hrs	1 🗆 \	ryatWork? Yes 2. ✔ No	o Operator of	how injury occurred f motorcycle which s	
Divisior Hospital or Attend 24 hours after death. Funeral Director: tely filled in by the 1	Certification:	4 Homicide determined (Spe	Place of Injury - At home, ecify) Major Road / I		factory, office b	uilding, etc.	or Town	Street and Number or Rui State) & Middle River Road, N	
To the Hos within 24 h To the Fun	edical		e best of my knowledge, o asis of examination and/o ner stated.	death occurre or investigation	n, in my opinion	, death occur	, and due to the cau red at the time, date	and place, and due to the	e cause(s)
		29b. Signature and title of certifier	lle		29c. Licens O.C.I		_	29d. Date signed (Mon	th, Day, Year)
2	- 1		sistant Medical Exa	miner 1	11 Penn St	reet, Baltir	more, MD 2120)1	
St Regist	ate rar	31 APR 2 2 112 PH Tear) Server 3	2. Registrar's Signature						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Dale 2011 6:30 AM Medical <u>April</u> 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
March 24, 1924 g. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Yrs Michigan **Director** 87 382-14-9920 Usual Residence of Deceden show or 28a-f shove notified at 10a. State the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Chevy Chase 1 Yes 2 No 10e. Street and Number and Mental Hygiene. Is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be 1 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 8100 Connecticut Ave. United States 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

X Yes 2 \sum No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. W.W. 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Economist Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) errit. Page 1 and 2 should be fee artment of Health and Menta nportant: If item 27 is marked ny injury or other traumatic ev ပ္ (Unk) (Unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8100 Connecticut Ave., Chevy Chase, MD Joy I. Dale / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Chesapeake Crematory 4/29/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) permit.
Dec artm
Importa
any inju 21. Signature of Funeral Service Licens Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Newsmant disease or condition une anoma metastatic Medical resulting in death) s a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (cras a consequence of): Examin Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death the Unknown 9 Unknown P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy death? After this certificate 1 Yes 2 No Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural WILLIAM 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No the Investigation 6 Could not be within 24 hours after deat

To the Funeral Director:
completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge; deat the time, date and place, and due to 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 43083 April 16,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9107 MEDICAL CONFEDR #300 ROCKVILLE MIS GEURGE A SOTUS 20850 MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:00 PM <u>April</u> 201 Donovan Medical Melania 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 717 Druid Park Lake Drive Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9 Birthplace (State or Foreign Damid)1Can **Funeral** 1 □ M 2 💢 F Months Days Hours Min. (Month, Day, Year) Aug 20, 55 Director 119-50-1390 1955 Republic Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland rral", or items 23a or 28a-f sho Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21217 <u>717 Druid Park Lake Drive</u> permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked official any or others. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔼 No 1

Yes 2 □ No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Hispanic Year or Dates Dominican Repub 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Hospitality Bartender Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Yvan Gibbs Carolina Yunque 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Nelson /Daughter 3740 Ellerslie Avenue Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Apr 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 Signature of Funeral Service License 22. Name and Address of Facility Cremation and Funeral Alternatives Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year . ☐ Yes 2 No 9 ☐ Unknown Pregnant at time of death 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has b page 2 s autopsy certificate Yes after death.

Director: After this certific
in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: 2 🗆 No ၉ Yes 4 Nursing Home 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpa 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 1 Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s only one 29b. Signature Dav. Year

Registrar

State

Ivent St Baltimore

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no completed cause

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32. Registr#'s Sign

30. Name and address of person

31. Date filed (Month, Day, Year)
APR 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Anni John Raymond Dushel 2011 5:11 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign Days Hours Min ^{Year)} 19<u>58</u> 1 X M 2 🗆 F May 29 Maryland **Director** 213-72-0925 Usual Residence of Decedent 28a-f show is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Harford Joppa 1 🗆 Yes 2 🎽 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 Enfield Road 21085 **USA** 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 9 1 Never Married 2 K Married 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates White 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ice Cream Manufacturer Maintenance Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leroy Joseph Dushel Frances Emma Reick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 501 Enfield Road, Joppa, MD 21085 Wanda L. Dushel / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-22-11 Baltimore, Maryland Oak Lawn Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac ar respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ arunor Ocarchia disease or condition Hour Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical 1N MCCO 20 J. Records, P.O. Box 6876 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an John 2 No 1 Yes 2 No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 2 V No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Sushe 1 V Natural 5 Pending injury 2 Accident
3 Suicide 1 Tes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 🗋 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2

To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29d, Date signed (Month, Day, Year) anam April 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper ta 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Dorothy Evans MASS Medical April 1 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice at Northwest Randallstown Baltimore 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 13 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Min. Hours Director 235-74-2087 Dec 1945 Usual Residence of Decedent show at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sl other traumatic event, the Medical Examiner must be notified. MD Carroll Sykesville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7311 Second Avenue 21784 USA and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) certified <u>nursing assistant</u> health care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. George L. Nickleson Helen M. Kessel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4035 Wheatland Ct., Hampstead, MD 21074 Donald W. Evans (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ebenezer Church Cem. 4-23-11 Romney, WV Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel Daige Hought Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CardioThrombotic Event Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ATherosciendric cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? ed by the a detached f Hospital or Attending Physician: The law requires that the signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy death? this certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 6 Other (Specific) 1 Yes 2 1 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence thin 24 hours after death.

the Funeral Director: After thi
mpleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Pwithin 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MSRUUPAMIMID D0057465 4/19/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) d. Baltimore, MD. 21709 263 NS Rajapakse, M.D 2835 Sm12 AV

Registrar

State

31. Date filed (Mor

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:20 1 M Robert Edwards J. 2011 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Home Havre De Grace artor 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🔀 M 2 🗆 F May 2. 1919 Hours Director 218-10-6435 91 Indiana Usual Residence of Decedent 28a-f show 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Harford Aberdeen ¹XXYes 2 ☐ No 10e. Street and Number 'n 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 206 Edmund Street items 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. "natural", 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. Is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 civil service US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Edwards Dorsey Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is or other Gregory Edwards (son) 425 Gorham Rd., Scarborough, ME 04074 Baltimore, 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Paul's Cemetery 4/20/2011 Aberdeen, Maryland 21. Signature of Funeral Service Liv 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Pheliminia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or as a consequence of Kutensin Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Dav Year signed by the 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> •• or Hospital or Attending Physician: The law requires twithin 24 hours after death.

To the Funeral Director: After this certified completed filled in hearth. Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 40 Yes 2 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month; Day, Year) 181 Name and address of leted cause of death (Item 23a) (Type, Print) 2/078 31. Date filed (Month, Day, Year, State Registrar

Robert

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11-02835 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Chantell Ciera Ford State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day April 13, 2011 CiEra Medical Examiner hantel 2142 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Director Months Days Hours Min. 13-5939 2 V F Country) 1 M Yrs 980 Usual Residence of Decedent ij 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once more Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Parkwa Falls Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married White, etc. 2 Yes 3 Widowed If Yes, Give Year 4 Divorced 1 Yes 2 No specify: Specify: Black ≦ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Silrname Ford lavence 19a. Informant's Name/Relationship (Type, Print) (Mother) 1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GWYARS 160 Fall 110 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State crematory or other place) Donation 5 Other Specify emeter 2 Name and Address of Facility nature of Funeral Service Licansec Home, P.A. Joseph W. 10rth AVE Part I. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Multiple Gunshot Wounds Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED has been signed by the attending physician e 2 should be detached for use as the burial **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? After this certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 / Inpatient 2 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 1 🗸 Yes ۵ 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Apr 13, 2011 1 Natural Subject shot 2051 hrs 5 Pending within 24 hours after death.

To the Funeral Director: 1 Yes 2 V No in by the Investigation 2 ___ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 4500 Blk. Winchester Road, Baltimore . MD determined 4 V Homicide (Specify) Local Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E April 14, 2011

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111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Ling Li. MD

31. Date file porth 2 2 201

OCME

Division of Vital Records, P.O. Box 68760,

Physician •			Decedent's Name (First, Middle, Last)	Date of Death Month Day Year		3. Time of Death			
			JOY MARGARET GRIJALVA		APRIL 20	,	8:15 A M		
and a	/Medical Examiner 4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death 4c. County of Death					
e de la constante de la consta			408 PATRIOT'S WAY	ELKTON		CECIL			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea		lace (State or Foreign atry)		
	Director		377-34-3930 62		Aug. 19,	1928 En	gland		
	and w		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location						
	Maryl	ţ	Maryland Cecil Elkton				XXXYes 2 ☐ No		
	the 1	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Cour	ntry?		
	3a o		408 Patriot's Way	21921	ט	.S.A.			
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ Black, White,			
9	after or ite		1 □ Never Married 2 □ Married 1 □ Yes 2 1 □ No	1 □Yes XXNo Specify:	o riidari, etc./	Specify: Wh:			
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ent, the Medicel Exerction must be notified at	d by	3 ☑ Year or Dates:						
5	"nati	Completed	15. Decedent's Education 16a. Decedent's Education (Specify only highest grade completed)	cedent's Usual Occupation ve kind of work done during most of wor v. DO NOT use retired)	king	Kind of Business/In			
12	withir ene. than	Ĕ	Elementary/Secondary (0-12) College (1-40r 5+)	retary	00.	hns Hopki plied Phys			
	filed Hygi ther		17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maid				
an	d be ental ked c	To Be	Walter Scott Gilmour	Gwendol	yn Pearce				
Maryland	shoul Ind M I mar	-	19a, Informant's Name/Relationship (Type. Print) 19b. Ma	illing Address (Street and Number or Ru	ıral Route Number, Cit	y or Town, State, Zij	Code)		
	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Heath and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it s Marical Examin		Stanley Czajkowski /son-in-law 1 D	utton Avenue Cato	nsville, M	aryland	21228		
ē,	of He		20a. Method of Disposition 20b. Place of Discemetery, c	position (Name of rematory or other place)	Date 20c.	Location - City or To	wn, State		
E	Pages nent of hant: If ite	١.	1 XXurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Union Co		/2011 Bu	rtonsvill	e, Maryland		
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tr. once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Donaldson Funeral	Home, P.A	_			
<u>m</u>	8 9 E 8 9		/ M00770	313 Talbott Avenu	e Laurel,	Maryland	20707		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not on shock, or heart failure.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death		
may.	Physician		Immediate Cause (Final disease or condition	DULLSA			Weeks		
	/Medical Examiner		resulting in death) Due to (or as a consequence of):						
	LAdillilei	<u>_</u>	Sequentially list conditions, if any leading to immediate b. Endo Co. 94 T7 Due to (or as a consequence of):	8			weeks		
19	ted sit	nin	cause. Enter Underlying Cause (Disease or injury	NO BOOMERIT	tim.		1100 be		
1	execunand al-tra	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):	ve Begurgita	1:0.		W CC 123		
760	e be sicia buri		L _d .						
30x 68760,€	tifical ng phy as th	an/Medical							
ŏ	th cer rendir	N/ue	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of deliv	,		
Э.	ed for	sicis	In the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant at time of death	5 Other (specify)		Month	Day Year		
P.0	at the	Physici	9 Unknown	and the delivery of the second to Dental	220 Did tobacc	co use contribute to	ho cause of death?		
s,	res th		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1 □ Yes		bably 4 🗆 Unknown		
orc	requi	Completed by							
Sec.	e 2 sl	nple			24a. Was an autopsy performed	24b. Were auto prior to co death?	opsy findings available ompletion of cause of		
<u>=</u>	r. The	වි			1 □Yes 2 🗗		2 1 No		
Zi.	ician certif	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Othory	ath (Check only one)				
Division of Vital Records,	Phys rthis ral dii	l:	1 Tes 2 TNO 1 Inpatient 2 EH/Outpa	tient 3 DOA 4 Nursing F	lome 5 Residence		fy)		
on	ding h. Afte fune	ţi	27. Manney of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation			.,,			
S	Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be 28e, Place of Injury - At home, farm,	street, factory, office	28f. Location (Street	t and Number or Rui	al Route Number,		
Ö	al or after	Certification: To	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Si	tate)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/o and manner stated.						
	orthe orthe	Mec	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	Dayj Year)		
	F > F 0) COLD, MD	D0065	827	4/20	/2011		
	10		30. Name and address of person who completed cause of death (Item 23a) (Type Rule Mills 500 U	e, Print) PRV Chesaplak	e Rd Bel	air m	21014		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	R					
	Regist	rar	ADD 2 2 2019 June 1. A	ark					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Shirley Katherine Grove 9:45 P_{M} 19 **April** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Stella Maris Hospice Center Timonium 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Feb. 9, 1939 Hours Min 212 36 4473 72 Director Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Harford Forest Hill Maryland 1 Yes 2 XNo 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 802 Delray Ct. 21050 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. "natural", or ģ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Utilities Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bernard Gietka Katherine Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 802 Delray Ct. Forest Hill, Maryland 21050 Duane Robert Grove (Husband) injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, Oak Lawn Cemetery 4/23/2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. any 1407 Old Fastern Avenue Essex. Maryland 21221 Fat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PANCREATIC CANCER Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): nding physician and use as the burial-transi Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter the detached for u in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page Yes 2 X No 1 Yes 2 🗌 No Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 N Other (Specify) 2 X No 잍 1 Inpatient 2 ER/Outpatient 3 DOA After this HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) injury 5 Pending after death. 1 Yes 2 No Accident Investigation M the 3 Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 🛣 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Da State Registrar

SHIRLEY GROVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OREEN 9:29 AM APRIL 2011 NNA Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death JORTHWEST KANDALLSTOWN BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours 04-07-2 1 M 2 X F 250-26-4910 88 SC Director Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD ÑΑ Baltimore X 1X Yes 2 No 10e. Street and Number #212 10f. Zip Code ō 10g, Citizen of What Country? Funeral items 23a 2725 Walbrook Avenue Apt. USA 21216 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, et African 11. Marital Status Armed Forces?

1 Yes XX No and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married 3 Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates Specify: American 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Domestic other homes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Worm Rapley Frances Rapley permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 John Mims-Son Lockwood Road Baltimore, MD3617 Baltimore, 20a. Method of Disposition

1 🗡 Burlal 2 🗆 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 04 - 29 - 11Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD Wylie FuneralHome P.A. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gilmor Street Baltimore, MD 21217 638 N.23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death SEPSIS Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DAYS PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injuthat initiated events resulting in death) Last Due to (or as a consequence of): ending physician are use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) atter in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Yes 2 N 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 X No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident
Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check To the within 2 only one) 29b. Signa 29c. License number 29d, Date signed (Month, Day, Year) 2011 0006029 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21133 RANDALL STOWN AHMED 5401 OLD COURT RD M.D MURTURA 31. Date filed (Month, Day, Year) 32. Registrar's State APR 2 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ nonth 11:16 nte 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bayvicen (Baltmore Center If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Days July 31 Min. Year) 1951 241-84-1324 North Carolina 59 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 648 Peach Orchard Lane 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: black "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. mechanic automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Howard Crews Willie Dunlap 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $648\ Peach\ Orchard\ Lane\ Dundalk,\ MD\ 21222$ Sarah Gunter/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) rector ²State^{and} Addast of Figure Board 655 W. Baltimore Street Baltimore. MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between shock or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition POXIG Medical resulting in death) Due to (or as a consequence of) Examiner ubarachnoid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated second Examine that the death certificate be executed the burial-transi racheostom that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical tension for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year ate has been signed by the a page 2 should be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of aneur 24a. Was an autopsy performed death? After this certificate 2 🗌 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific, completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) xaminer? 1 █ Yes 2 ☐ No Other: 1 XInpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d, Date signed (Month, Day, Year, 0 5 DVI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hoskins 5505 130 W.B. Greehough I MO \$417 nove 875 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

		•	1 - State of Maryland / Dep State Registrar Ce	ertificate of De			2011	12922		
F	Physicia		1. Decedent's Name (First, Middle, Last) Marian M. Graf			2. Date of Death Month April 2	1, 2011 Year	3. Time of Death 12:48 A M		
	Medic Examin		4a. Facility Name (if not institution, give street and number) Stella Maris	4b. City, Town, or L	Location of Death		4c. County of Death	1		
	uneral irector	S)	5. Social Security Number 219-01-7264 6. Sex 1 □ M 2 ♣ F 7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Ye	9. Birti	pplace (State or Foreign		
	show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation				10d. Inside City Limits		
e Maryla	r 28a-f s notified	Funeral Director	Maryland Baltimore County Timonium 10e. Street and Number					1 Yes 2 No		
h with th	with the s 23a or lust be r	nerall	2300 Dulaney Valley Road	10f. Zip Code	21093	100	United St			
21215-0036 within 72 hours after deat	Department or nearth and wenter prytheries are proportionally or items 23a or 28a-f show monotant: If then 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates.	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☒No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:			
215- (an "nat Medica	eldud	(Specify only highest grade completed) (Give	edent's Usual Occupat e kind of work done du DO NOT use retired)	tion uring most of worki	ing 16	b. Kind of Business I	ndustry		
d 21	other th	d) t	12 04 17. Father's Name (First, Middle, Last)	Home Make		e (First, Middle, Mai		Home		
Maryland 2 should be filed	iarked catic eve	힏	John Aaron MacDonald		Mary Mie					
d2 shou	12 should alth and h			ing Address (Street an						
Baltimore,	tant: If item lury or other		20a. Method of Disposition 1 Burial 2 **Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition community and state Search Full C	osition (Name of majory or other place) at Chapel an Services, Inc	d Fri April		c. Location - City or (Harford Orest Hil	d County) 1,Maryland		
Balt permit.	Import any inj once.		21. Signature of Funeral Service Linensee Jeffrey L. Gair, Sr.	2. Name and Address Cacciful Alice 2325 York Ro	of Facility	uneral and mium,Maryla	Cremetion Cand 21093-2	nter, P.A. 2215		
N	sician/ ledical aminer	23a. Part 1. Inter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
760 cate be executed	physician and the burial-transit									
Box 68 death certif			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of deli	very Day Year		
ds, P.O. quires that the	en signed by ould be detar	23e. Did topacco use contributing to death but not resulting in the underlying cause given in Fart i.								
Recor	cate has be page 2 sh	Completed				24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of		
ital	certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inputient 2 FR/Outpatient	Other:	ce of Death (Check	(only one)				
Division of Vital Records, tal or Attending Physician: The law requires after death.	r: After this e funeral dir	Certificate: To	27. Manner of Death Natural 5 Pending (Month, Day, Year) Accident Investigation	of 28c. Injury a work?	28c. Injury at work? 28d. Describe how injury occurred		59)			
Division atte	I Director:									
e Hospit	To the Funeral D completed filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investorily only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion,	, death occurred at	the time, date and p	lace, and due to the c	ause(s) and manner stated.		
To th	To th		29b. Signature and title of certifier Preis CRNF	29c. License n			Date signed (Month,			
5 v	/		30. Name and address of person who completed cause of death (Item 23a) (Type, JUSTINE PREIS, CRNP 2300 DUL.			TIMONI	JM MD 21	093		
	Stat Registra	٠ ا	31. Date filed (Month, Day, Year) APR 2 2 2011 32/Registrar's Signature	ake						

12:48 A.M.

APRIL 21, 2011

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State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 02:54AM loney J. Goodman 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) 1 M 2 □ F Months Hours Min Director aru Usual Residence of Decedent 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. event, the Medical Examiner must be notified at 10c. City, Town or Location 16d. Inside City Limits Director 1 2 Yes 2 □ No MOVA 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4020 21218 items ; 12. Was Decedent Ever in U.S. 1. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ŗ, <u>6</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: than "natural", 3 Divorced Completed lac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. lec Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sur မ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Lity or 27 permit. Page 1 and 2 Department of Healti Important: If item 2: any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 💆 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral/Service Licens 22. Name 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sophageal disease or condition Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ne if any, leading to immediate cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Exami the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached. g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Vonknown 24b. Were autopsy findings available prior to completion of cause of death? performe 2 1 No Yes 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 **Y** No Other: Certificate: To 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier Mekonen, M.D. **Eyasu** 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eyasu rekonen, 5601 Raven Lock Boulevard Baltimore 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2, 15 Å M Physician/ Calvin Gerst Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Washington Med Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last hirthday **Funeral** Days Min Oct 21. 1 X M 2 D F 227-30-1776 81 Virginia Director T929 Usual Residence of Decedent or 28a-f show 10a. State 10b. County with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 2912 Belmont Avenue 21216 USA Page 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🕅 No Specify. Specify: black Completed 3 Widowed 4 X Divorced Year or Dates. Army 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) janitorial public schools Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 2 Andrew Jackson Maddie Gerst 19a. Informant's Name/Relationship (Type, Print)
Annie H. Woodson
Annie Woodson/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14701 Claude Lane Silver Spring, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town. State permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place) Garrison Forest Veteran 5/12/2011 Owings Mills, MD 4 Donation 5 Tother (Specify) in state Howell Superal Home 4600 Liberty Heights Ave. Balto. Who Baltimore, MD 21201 Signatur of Euneral S elicensity e Darector 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cause or each line Immediate Sause (Final neumonia Onset and Death Ph sician/ Medical resulting in death) Prostate Cancer Due to (or an a consequence of); Examiner etestatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown cate has been signated by page 2 should by Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No Yes 1 L Yes Be 25. Was case referred medical 26. Place of Death (Check only one) Hospital 2 No Other: ဂ္ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manna of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work?
1 ☐ Yes 2 ☐ No neral Director: At filled in by the f ☐ Accident ☐ Suicide Investigation 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. WS

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GRUS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 0244 AM Sarv 16 2011 to /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month) Days Hours Min. Dec 31, 1949 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months unk 1 🕅 M 2 🗆 F 61 219-50-6149 Director Usual Residence of Decedent 10a State 10b. County 10d. Inside City Limits show 10c. City, Town or Location the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Baltimore MD 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be n USA 21224 1300 S. Ellwood Avenue Funeral unk 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No U Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. unk 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. ۾ If Yes, Give Year or Dates: Specify: white 3 Widowed 4 Divorced Completed THE 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John Hopkins Bayview Hospital 4940 Eastern Avenue Baltimore, MD 21224 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ▼ Other (Specify) in state 21. Sign ture of Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediat Cause (Final disease or condition resulting in death) Onset and Death Sepsis

Due to (or s a consequence of): **Physician** hours /Medical Examiner arduo minutes Sequentially list conditions, any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a someoguence of requires that the death certificate be executed burlal-transi and resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy In the past 12 months? Pregnant at time of death signed by the att 5 Other (specify) 2 No 9 Unknown P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy has 1 🗆 Yes 2 NO 1 ☐ Yes 2 🗆 No certificate Be 26. Place of Death (Check only one) Hospital: Other: 4 🗆 Nursing Home 5 🗆 Residence 2 ☐ ER/Outpatient 3 ☐ DOA 1 \square Inpatient ρ 28a. Date of Injury this completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Director: After or Attending 5 Pending investigation Injury 1 🗌 Yes death. 2 🗆 No 2 Accident 3 ☐ Sulcide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide after Hospital Funeral 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifie D70969 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dart Brow 4940 Eastern Avenue, Baltimore, MD, 21224 park 31. Date filed (Ma 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edna Louise Harris 2011 April 3:20p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 8. Date of Birth

(Month Day, Year)

Jan 12 1926 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □ M 2 ⋤ F Months Days Hours 85 Director 214-20-2876 Usual Residence of Decedent 23a or 28a-f show ast be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene.

Department of Health and Mertal Hygiene.

The moundant If the m 27 is marked other than "natural", or items 23a or improvant If the m 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be. Funeral 4927 Cherry Tree Lane 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐XNo Specify: white 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Pittsburgh Plate Glass brush maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Florence Stauffer Howard B. Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Merryman (sister) 4927 Cherry Tree Ln., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 4-25-11 Elkridge, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Paraget Hought Sterber P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Velleur Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other signific to onditions contribution to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s this certificate has autopsy performed death? 2 🗷 No Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hesice To the Hospital control within 24 hours after death.

To the Funeral Director: After this control and the funeral control and 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the Sest of my knowledge, death pround at the time, date and place, and due to the 29b. Signature and title of certifier 22/204 ie 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 21130 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Day 15 2011 Physician/ 2:20 P Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 39637 Poto<u>mac</u> St. Mary's Compton Avenue Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 577-44-3054 Yrs **Director** Virginia Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD St. Mary's Compton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 39637 Potomac Avenue 20627 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 V Yes 2 No 1950If Yes, Give
Year or Dates. 1952 Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electronic Engineering Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once, Juanita Pollock John W. Haggerty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3568 Belfry Lane, Woodbridge, Robert G. Haggerty Jr. VA 22192 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 4-19-11 Cremation Inc Hanover, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael 6009 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ HROA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending plants of the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe After this certificate 2 🗌 No Yes 2 N 1 Tyes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after dea: To the Funeral Director: Suicide 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBOX 186, MECHANICSVIlle Medaylone 20659 201 MD FOCS State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Day 2011 Physician/ April 10, 1:50 AM M <u>Anna Louise Jones</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Center 8. Date of Birth (Month, Day, Year) Mar 19, 1939 If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 🗆 M 2 🗓 F Pennsylvania Director Vrs 213-36-2413 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No MD Towson Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5401 Acorn Circle #201 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Specify Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 healthcare medical assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ൧ Della Elizabeth Thompson James Frank Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7878 Kavanaugh Road Dundalk, MD 21222 Rose Shindle/executor 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 X Donation 5 Other (Specify) Signature of Euneral Service Licenses Ronal d 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Raltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shook, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Compared time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year 1 Yes 21 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ Yes Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 1 🗌 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 5 Pending Accident Suicide M Investigation after death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Hospital Medica 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie onocce name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Box 68760

P.O.

Records,

of Vital

Division

			Please 1	ype or Print in Black		•			
			For State	State of Maryland / De	•	and Mental Hygien	né Uli 12991		
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg. N	No. 3. Time of Death		
	Physicia Medic		Johnann	a	Lee		7. 2011 6:50 P M		
	Examir		4a. Facility Name (if not institution, give sti		4b. City, Town, or Location	of Death	4c. County of Death		
1	Future Care Charles Village N. H. Baltimore 5. Social Security Number 6. Sex 17. Ade (in vis. last birthday) If Under 1 Year 1 If Under 24 Hrs. 8. Date of Birth 9. Birtholace								
	Funeral Director			M 2 1 F 7. Ade (In yrs. last birthday)	Months Days Hours	24 Hrs. 8. Date of Birth Min. (Month, Day, Year	9. Birthplace (State or Foreign Country)		
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	arylan a-f sh fied a	Director	MAN NIA	Toc. City, Town 6	(1)		10d. Inside City Limits 1- ☑ Yes 2 ☐ No		
	the M	Ω	10e. Street and Number	1300	10f. Zip Code	109.	Citizen of What Country?		
	h with	Funeral	501 Dolphin S	street #311	2121	7	USA		
(0	or iter		11. Marital Status 1 1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	igin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.		
903	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Completed by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	1 ☐ Yes 2 ☑ No Specify		Specify: Black		
15-(72 hou n "nati ledica	nplet	15. Decedent's Educ (Specify only highest grade	completed) (G	ecedent's Usual Occupation ive kind of work done during mos	at of working	Kind of Business Industry		
21215-0036	within /giene.		Elementary/Seconday (0-12)	College (1-4 or 5+)	e. DO NOT use retired) Home make	0	wa Home		
	filed vida other	To Be	17. Father's Name (First, Middle, Last)	i		er's Name (First, Middle, Maide	on Surname)		
Maryland	should be file and Mental H 7 is marked o raumatic eve	🖺		ster		argaret	tair tax		
Ma	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.		19a. Informant's Name/Relationship (Type	in a Daughter) 196. N	$\Delta i i i i i i i i i i $	er or Rufel Route Number, City	or Town, State, Zip Code) 2/267		
ore,	of Health of Health fitem 27		20a. Method of Disposition	20b. Place of D	sposition (Name of crematory or other place)		Location - City or Yown, State		
Baltimore	Page tment o tant: If jury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State King N	emorial Park	4/23/2011 W	Godlawn, MD		
Ball	permit. Page 1 Department of Important: If i any injury or c		21. Signature of Funeral Service Lice see	,	22 Name and Address of Facili	Euss Funeral H	lone, P.A.		
			23a. Part 1/ Enter the disease, or complice	ations that caused the death. Do not	2327 W. NOY enter the mode of dying, such as	cardiac or respiratory arrest,	21216 Approximate		
	hysician/	1 19	shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	a Reely	~0	Interval Between Onset and Death		
1	Medical Examiner		resulting in death) a.	Due to (or as a consequence of):	0	,			
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	executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	myelody	stolantre de	sorder			
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Box 68760	or Attending Physician: The law requires that the death certificate be affer death. Interdor: Adhr. Pilmerder death. Interdor: Adhr. Pilmerder death. In by the funeral director, page 2 should be detached for use as the but by the funeral director.	Physician/Medical	d.	104 peres	ten				
89	ath certifice attending p for use as t	M/ne	23b. Was decedent pregnant	e. If yes, outcome of pregnancy	3 Ectopic pregnancy		23d. Date of delivery		
B 0)	t the death by the att	/sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown	5 Other (specify)		Month Day Year		
P.O.	that the led by detack	y Ph	Part II. Other significant conditions cont	ributing to death but not resulting in the	ne underlying cause given in Part	I. 23e. Did tobacco	o use contribute to the cause of death?		
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cord	aw req as bee 2 sho	Completed	<i>U</i>			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
of Vital Records,	ician: The law certificate has rector, page 2 s					performed?			
/ita	ysician: iis certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 Ho	spital: 1 Inpatient 2 ER/Outpa	Other	ursing Home 5 Residence	6 Other (Specife)		
of	ng Phy ter this neral o	11 21	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year) 28b. Tim	e of 28c. Injury at	28d. Describe how inj			
ion	ttendii death. :tor: Al	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 ☐ Yes 2 ☐				
Division	al or A s after I Direc d in by		4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, Sta	and Number or Rural Route Number, tte)		
_	To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral dire	Medical		an: To the best of my knowledge, dea			and manner as stated. ice, and due to the cause(s) and manner stated.		
	the Fithin 2, the Formplet	Me		Practioner: To the best of my knowledge		e and place, and due to the caus			
	5 5 6 8		Den Dignature and title of certifier	mo	D 314		ULS III		
J			30 Name and address of person who com		e, Print)				
			31. Date filed (Month, Day, Year)	LOHMI MD. 8:	21 N. BITAW	ST Smt 3	Of BALTIMOREMP.		
	Stat Registra		APR 2 2 2011	32. Registrary Signature					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARTHA Month 2 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANDALISTOWN ALCEM Conton If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** If Under 9. Birthplace (State or Foreign 1 🗆 M 2 🗆 F Months March 18, 116-34-6946 69 1941 NY Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Carroll Sykesville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7200 Third Avenue A-310 21784 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Page 1 and 2 should be filed wit ment of Health and Mental Hygier ant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dause Bibby Virginia Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 15412 Snowhill Lane, Centreville, VA 20120 (Personal Rep.) Mr. Eric Dean 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) All County Cremation 4/20/2011 Sykesville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA Haist MO0769 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ EPSIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner UNDAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last URINARIS -tran and Due to (or as a consequence of) burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 mont 2 100 Yes page 2 should be detached signed by the Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 2 110 2 1 No 1 Yes Yes No the nouse after death.

Within 24 hours after death.

To the Funeral Director. After this certifice 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 Thipatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 atural 5 \square Pending 1 Tyes 2 🗆 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Letrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete ed cause of death (Item 23a) (Type, Print) ONANA ORIHADE 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 18, 2011 Frank Joseph Moyna 8:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day Country) New York 1 🛛 M 2 🗆 F Days Hours **Director** 79 046-24-6342 Mar. Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Harford Bel Air 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 705 Clara Terrace 21014 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. Completed by 1
Never Married 2
Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-003 Specify: 3 Widowed 4 Divorced White Year or Dates marked other than "nature matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Machinist U.S. Government permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important if item 27 is marked other any injury or other traumatic event, ti once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Arthur James Moyna Marie (nmn) Gibbons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin F. Moyna / Son 705 Clara Terrace, Bel Air, Maryland, 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'l Cem. Arlington , Virginia unk Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complicated is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Seotic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death ☐ Pregnam.
☐ Unknown 1 Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician; The law requires to the law requires to the law requires to the safter death. Division of Vital Records, Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been M900483187 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 M No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ✔ No Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HESAREAKE DRIVE BELAND MO 21014 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Roy Eugene Maines Sr. 2011 10:00 P **April** Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 508 Reckord Road Harford Fallston Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Teb. 27 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days Hours Min Yrs Director 218-32-9563 73 938 Maryland Usual Residence of Decedent show 10b. County 10a. State the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 🗌 Yes 2 🔀 No Maryland Harford Fallston ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 508 Reckord Road 21047 USA er than "natural", or items the Medical Examiner mu filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. ρ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Completed 3 Widowed 4 Divorced Specify: White 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Crane Operator Heavy Construction injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Department of Health and Ment. Important: If item 27 is marked any injury or other. John Robert Maines Clara Maddie Jennings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leta M. Maines / Wife 508 Reckord Road, Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn. 4-23-11 Bel Air, Maryland 21. Signat /e of F // ral Service Livensee 23. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or conshock, or heart failure. List only folications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to be cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Year Pregnant at time of death the detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? Director: After this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes hours after death. 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Yelar, Name and address of person who completed sause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 0 | | State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Registrar	Death	Reg.	. No	
Physicia	n/	Decedent's Name (First, Middle,Last)		Date of Death Month Death	Day Year	3. Time of Death 1623 hrs
Medical Examin			b. City, Town, or Location of Death	April 17, 20	11 4c. County of Death	
		4a. Facility Name (if not institution, give street and number) 549 Rising Sun Road	Rising Sun		Cecil	
Funeral	4	Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or
Director	- 1	226-59-8709 1 M 2 F 25 Yrs.	Months Days Hours Min.	Sep. 2	, 1985 Foreig	n _{Intry)} Virginia
	ľ	Usual Residence of Decedent				
ku k	Ī	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Aaryland 28a-f show	5	Maryland Cecil Rising Su	ın			1 Yes 2 No
Aaryl:	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cour	itry?
eath with the Maryland items 23s or 28s-f sho ust be notified at once.		549 Rising Sun Road	21911		USA	
h with	Funeral		Decedent of Hispanic Origin? (Sp s, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
r deat	티	1 Yes 2 No			Tufb	ite
s afte rral",	ক্র	or Dates:	Yes 2 No specify: s Usual Occupation (Give kind of v	vork done 1	Specify: Wh 6b. Kind of Business/I	
2 hour	ള		st of working life. DO NOT use reti		Commercia	T
336 thin 7 than edical	틹	1 Labore	er		Construct	ion
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Exami	Completed	17. Father's Name (First, Middle, Last)		(First, Middle, Ma	·	
21215-0036 ould be filed within 7 Mental Hygiene. I Marked other than ic event, the Medical	Be	Myles Christopher Morris		ne Ada C		
	우	(7)	Address (Street and Number or F			
Malth 2	ŀ		Rising Sun Road,		20c. Location - City or	
Baltimore, Nemit. Pages 1 and Department of Healt Important: If item injury or other trau		1 X Burial 2 Cremation 3 Removal from State crematory or other	er place)		- 71	
timent transfer	ŀ	4 Donation 5 Other Specify: Darlington	Cemetery 4- ame and Address of Facility M	21-11	Darlingto	n, Maryland
Baltimore permit. Pages i Department of F Important: If injury or other			317 Cokesbury Ro			
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the				Approximate Interval
/Medical	1	failure. List only one cause on each line. Immediate Cause (Final disease a. <u>Mixed drug intoxicatio</u> :	n Mathadana Ovy	odone Tr	amado1)	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. <u>Mixed drug intoxication</u> Due to (or as a consequence of):	ii (Methadone Joxyo	.odone,11	amadory	
	ا۔	Sequentially list conditions, b				
	Examine	if any, leading to limited at sauce cause. Enter Underlying Cause Clicase. Enter Underlying Cause C.				1
_ =	Xal	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	-			
O, e be executed ysician and burial - transit		d. X UNPENDED AMENDED 23a, 27, 28a-f, pe		1 cm		
60, ate be ex physician te burial	Medical		r me,g915 6-5-1.	ı sıı		l
376 ifficate ifficate ig phy s the t		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fett	al death 3 Ectopic pregna	ancy	23d. Date of delivery Month	/ Day Year
Box 687 e death certific the attending	Cia	past 12 months? 4 Pregnant at time of death 5 Oth	er (Specify)			
BO e deat the at the at	Physician	1 Yes 2 No 9 Unknown 9 Unknown				
hat th ed by		Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.		acco use contribute to 2 ✓ No 3 ☐ Prot	_
uires t	Completed by			24a. Was an		topsy findings available
cords, law requir	E E			autopsy perform	prior to o	completion of cause of
Rec The la	틹			1 ✓ Yes 2		es 2 No
Vital Rec ysician: The I his certificate I director, page	å	25. Was case referred to medical examiner? Hospital: 1 Innation 2 EP/Outnation	26.Place of Death (Check		esidence 6 🗸 Other	Seem
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. a) Director: After this certificate has been signed by led in by the funeral director; page 2 should be deaco.	의	1 Yes 2 No Rospital 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of In			w injury occurred	. Scerie
or of valing Ph.	<u></u>	1 Natural 5 Pending (Month, Day, Year) fd 4-17-11 fd 4:17	1 Voc 2 Fr No	_	. ,	
ivisior or Attend after death. Director:	ق	2 Accident Investigation 28e. Place of Injury - At home, farm, street	*	Unknown 28f, Location (Str	reet and Number or Ru	ral Route Number, City
Div ital or ral bif	Certification:	3 Suicide 6 X Could not be determined (Specify) Residence		or Town, Sta Rising S	te) 549 Risi: un,Md.	ng Sun Rd.
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr		due to the cause	(s) and manner as state	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	on, in my opinion, death occurred a			
F > F 0	Ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo.	nth, Day, Year)
		Mun Gramme Mes	O.C.M.E.		April 18, 2011	
·	ſ	30. Name and address of person who completed cause of death (Item 23a)	enn Street, Baltimore, MD	21201		
94-			om oneer, parimore, MD			
Sta Registi	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Margolese Eileen 9:00 # Medical APC. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3826 MENLO DRIVE N/A BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Months Days Min. Hours 67731^y/1950 Country) 219-48-5818 Director 60 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 XYes 2 No MD N/A BALTIMORE ě 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3826 MENLO DRIVE 21215 USA "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced WHITE the Medical 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME of Health and Mental Hygie if item 27 is marked other r other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ GOLDFEIN ROBERT SHIRLEY OBSTLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a lmportant: If item 27 is any injury or other transons. MELVIN MARGOLESE/HUSBAND 3826 MENLO DRIVE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗓 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BNAI ISRAEL CEMETERY 04/21/2011 BALTIMORE, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., Mark 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death leiomyosarloma Ph_sician/ Metastatic Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown for Day Year Pregnant at time of death g | Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be 1 Yes 2 No 3 Probably 4 Unknown been; 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed this certificate 2 🗌 No 1 Yes 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) 1 Natural 5 Pending М 1 Yes 2 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MS RayapakulM.D 4/21/11 DOUS 7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD, 21209 2835 Smith AV 5-203 N.S. Rayapakie, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ARU Mary J. McClelland 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Baltimore-Washington Medical Ctr. Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours Min 1 🗆 M 2 💢 F 212-34-4813 1/23/1937 Maryland Director Usual Residence of Decedent ra", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2806 Herkimer Street 21230 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian. Black, White, etc. "natura", or þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hyciene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 0 Homemaker and Mental Hyg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic James McCubbin Ella Brink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6515 Frederick Road, Baltimore, Maryland 21228 Anna Emmons / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Sonation 5 Other (Specify) 4/22/2011 Crestlawn Mem. Pk. Marriottsville, MD 21. Signal e of Funeral Service Licer 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avneue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Onepas disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Dav 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not sulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ Records. Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Division of Vital 1 Yes 2 N No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending after death. 2 No 1 Yes Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title 29c. License number

State Registrar Dawe, Gen

Burne.

of person who completed cause of death (Itam 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2011 Charlotte Estelle O'Donnell 18, 1:25 Рм April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8800 Walther Blvd. #2314 Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 □ M 2 🕅 F Baltimore, MD 214-22-2181 84 Oct. 6,1926 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits octant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the <u>Medical Examinar mast be nothed at</u> 28a-f shov Baltimore Parkville MD 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21234 8800 Walther Blvd. #2314 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 271s marked other than "--- any Injury or other than "---1 Never Married 2 Married 1 ☐Yes 2 🛣 No If Yes, Give Year or Dates: Specify: Specify: White þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home Housewife 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Walker Estelle Farley ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3629 Cornus Lane, Ellicott City, MD 21042 Cheryl Guth/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition April 21, 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkville, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Eachlith Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ icate has been sign, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 410 2 No 1 □ Yes 1 Tyes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🖟 o Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending n 24 hours after death. le Funeral Director: A bletely filled in by the fi investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier M 2011 30. Name and dedress of person who completed cause of death (Item 23a) (Type, Print) V)c6-8000 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

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12939 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Georgine Purcell Pearl Medical 10: P April 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hart Heritage Estate Forest Hill Harford 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Feb. 22 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Hours Min. 212-16-4386 1920 Mississippi Director 91 Yrs. Usual Residence of Decedent 28a-f shov 10a. State with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No |Maryland| Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 401 Autumn Harvest Ct. 21009 USA hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3X Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 72 and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) filed within Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 6 Vincent Michael Barranco permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. Josephine Antoinette Sassone traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Young / Niece Autumn Harvest Ct., Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp 4 Donation 5 Other (Specify) 4-20-11 Towson, Maryland 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ D disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and as the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 L relai us.
Pregnant at time of death in the past 12 months?

1 Yes 2 No Month Day Year sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🗓 No Other: 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 V Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Investigation 6 Could not be the Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one 29b. Signatu and title of certifie 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 22 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items 15,19a,b per 1h g914 4-22-11 vt
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1100 AM MANUEL POLIAKOFF Μ 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3211 FALLSTAFF ROAD BALTIMORE N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F Months Days Hours Min. Month Day, Year) 14 Director 214-36-8369 97 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? by Funeral 3737 CLARKS LANE, #208 21215 USA "natural", or items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Xyes 2 No Black, White, etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) RELIGION RABBI Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GUSSIE SCHWARTZ CHAIM RAPHAEL POLIAKOFF 9b Mailing Address (Street and Number, or Bural Route Number, City or Town, State, Zip Code)

3737 Clarks Lane # 208

3211 FALLSTAFF ROAD, BALTIMORE, MD 2121 19a. Informant's Name/Relationship (Type, Print) **Hadassah Poliakoff** 21215 ABBA POLIAKOFF/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State injury 4 Donation 5 Other (Specify) HAR HAMENUCHAT 04/21/2011 JERUSALEM, ISRAEL any inj once, Signa re of Funeral Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) rdiopu Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events esulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 $^<$ Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Day Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached? 9 Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiac 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 A Other (Specify) RESIDENCE Hospital: 1 ☐ Yes 2 🔀 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: X Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0056680 who completed cause of death (Item 23a) (Type, Print) 0 OM 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20**11** Physician/ Month 6:25 P M Helen H. Rowe April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George 13447 Overbrook Lane Bowie . Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 XF Months Hours Min. (Month, Day, Director 261-44-1903 Alabama Usual Residence of Decedent or 28a-f show 10a State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Prince George Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 13447 Overbrook Lane 20715 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify. and Mental Hygiene. is marked other than "natural", Completed 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Own Home <u>Homemaker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dr. Carlise Hays Harrison Evelyn Welch permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13447 Overbrook Lane, Bowie, Maryland 20715 John H. Rowe / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Ardent Cremation, Inc. 4/19/2011 4 Donation 5 Other (Specify) Hanover, Maryland 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, 6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. iterval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the bunal-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death led by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be de þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed Yes 2 death? Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the ft 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title D52139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SETAL MATTY 2401 Brandermill Blvd. Suite 230 Gambrill, MD 21054

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Mont)

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 per fh g914 4-26-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Month Day Physician/ Mildred E RICP 7:561 M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Northwest Seasons Hospice Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 X F Hours Min 219-14-0815 91 MD Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits within 72 hours after death with the Maryland Director notified MD NA Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be r Funeral 5229 Pembroke Avenue USA 21207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etcAfrican by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: American 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b, Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Professional Companion Self-employed 9th Grade NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Pearl Lvles John Gordon Lyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5229 Pembroke Avenue Baltimore, Maryland Joyce Fortune-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Meadowridge Cem. 1 X Burial 2 Cremation 3 Removal from State 04-21-11 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signatur 22, Name and Address of Facility 1206 West North Avenue William C. Brown Community Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End-Stage Cardiomy opening Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 M No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manger of Death completed filled in by the funeral 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) McReyaparnem.D D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N S Rajapa KSE M D . 6934 NVIATION BIVD Olen Burnie, MD. 21061 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

VOID

CERTIFICATE

2011-12943

SEE

CERTIFICATE

2011-13607

Completed 4.29-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Frederick William Schildwachter 2011 10:09a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carrol1 5. Social Security Number 8. Date of Birth (Month, Day, Year) Aug 3 1920 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) Birthp.... Country) MD 9. Birthplace (State or Foreign 1 □ M 2 □ F Days Hours 213-12-6025 90 Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location Director 10d. Inside City Limits MD Carrol1 Westminster 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 505 High Acre Drive 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian the Medical Examiner Black, White, etc. ò by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White "natural", Completed 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government ATF agent other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be file Department of Health and Mental I Inportant: If item 27 is marked o any injury or other traumatic eve once. ည F.W. Otto Schildwachter Marie Graf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Miller (friend) 2103 Leroy Dr., Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 4-23-11 4 Donation 5 Other (Specify) Pikesville, MD 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Parge Haight o erbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) is a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Year Pregnant at time of death signed by the a 9 Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Pooto has autopsy performed? Director: After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide hours after within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a Certifier (Check nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of m only one) edge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) DIVE -120 Ser 31. Date filed (Month; Day, Year) State Registrar

State Registrar

ZHANG

Box 68760

P.O.

Division of Vital

DHMH 17 Rev 7/2009

22 SOUTH GREENE STREET BALTIMORE, MD 21201

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	Funeral Director	Г	5. Social Security Number 213-46-3911	7. Ag 1 ☐ M 2 🔀 F	e (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		B. Date of Birth	9. Bi	rthplace (State or Foreign ountry)
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21215-0036 within 72 hours after death with the Mandard	freath and Mertal Hygiene, items are countries on the way yand the marked other than "natural", or items 29a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	MD 10b. County Cari	coll	10c. City,	Town or Loc		sburg			10d. Inside City Limits 1 Yes X No
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	it Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me		Richard Shank		and			and Number or Rural R Ln, Fink			
.	of Health	1	20a. Method of Disposition		20b. Pla	ce of Dispos	ition (Name of	Dat		Oc. Location - City or	
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Salt	Department Important: I any injury o		21. Signature Faneral Service Lie	ensee	-111	22.	Name and Addres	ss of Facility Fle	tcher	Funeral	Home
ш -	70 = 80		Thomas U.	Tunn				in St.,W			21157
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Vita	is cer direct	To B	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 EF	NOutpatient	Othe			ce 6 Other (Spec	ity Hospice
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Certificate:	4 Homicide determine			e, farm, stree	et, factory, office	28f	f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
Hospit	24 hour	Medical	(Check 2 L Medical Exa	hysician: To the best of miner: On the basis of ex	camination ar	nd/or investig	gation, in my opinio	n, death occurred at the	e time, date and	place, and due to the	cause(s) and manner stated.
o the	vithin .	- I	only one 3 Certifying N 29b. Signature and title of certifier	irrai Practioner: To the t	sest of my kr	towledge, d	29c. License	time, date and place, a	and due to the ea	uce(c) and marmer ac d. Date signed (Month	etated.
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	9		30. Name and address of person wh				int)	la		/ 1/ · · · · · · · · / /	- 1.7
	D		1 Date filed (Month Day Year)		5P1		92.50	K 307	veim	insper r	0 21157-
-	Stat Registra	e	APR 2 2 2011	32. Registra	r s Signature		9				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 31 per dvr g914 4-22-11 vt State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ANTHONY Physician/ AUT 1 Month Day 6:20 P M 2011 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie **Arundel** Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min (Month, Day, Year) 2-24-1948 Country)
Washington, DC 62 Director 215-46-0233 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County with the Maryland Director notified 28a-f 1 Yes 2 X No Millersville MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ms 23a or must be 1108 Indian Landing Road 21108 United States items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married ō Completed by Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 Widowed 4 Divorced White Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

7 is marked other than traumatic event, the Me United States Federal Elementary/Seconday (0-12) College (1-4 or 5+) Protection Service Police Officer 12 Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dorothy Dunklee Nicola Santini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a
If item 27 is
or other tra 1108 Indian Landing Road Millersville, MD 21108 Wanda Santini / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important; If it any injury or o cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 04-21-2011 Olivet Cemetery 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. Signature of Funeral Service Lice Annapolis Road Odenton, Maryland 21113 <u> 1411</u> a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIABSTES Physician/ disease or condition / Medical resulting in death) **Examiner** CO REDWA CRETEROD D E Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine HUPER or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year 1 Yes 2 L 9 Unknown the be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 2011 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -WREQ DUARINO 5711 Sarvis Ave. Riverdale, Maryland 20737 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Year 9:20 am William George Stauffer, SR. 04 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Samaritan Himore 600d 150 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □XM 2 □ F Months Days Hours Min. Director 208-30-1698 7/25/1941 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10h County 10d. Inside City Limits Director 1 □Yes 2 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3104 Edgewood Avenue 21234 U. S. A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣No Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Director Retail Sales Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Curtis George Stauffer Ruth Marie Nickerson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) William George Stauffer, Jr. 3104 Edgewood Avenue Parkville MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 4/19/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician GI bleed disease or condition resulting in death) /Medical Due to o as a consequence of): Examiner Sophagea Sequentially list conditions, day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): burial-transit and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Year Day signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à is certificate has been si director, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 DNo 1 ☐ Yes 2 □ No 1 □Yes Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Blyd. Baltimore, 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AMOPTI 19 pay 2011 Year 1:50 Edward Carr Shepp Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 - F Days Min. Hours April 23, 1918 216-05-7252 92 Mary land Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f MD Baltimore Catonsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o by Funeral 716 White Oaks Ave 21228 USA and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 □ No If Yes, Give Year or Dates. WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 XWidowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Computer Installer **IBM** of Health and Mental Hygi item 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Joseph Francis Shepp Marie Otellia Mulcahy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 716 White Oaks Ave., Catonsville, MD. 21228 Dale F. Kennedy Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important, If ite any injury or oth 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛣 Other (Specify Entombment Loudon Park Cemetery 4/26/11 Baltimore, Maryland Signature of Funeral Service 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Bacteremiz disease or condition meric Medical resulting in death) Due to (or as a consequence of) Examiner man Sequentially list conditions, cause. Enter Underlying Due to (or as a conseque Examil -transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year ed by the a detached f Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 les 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Tes Other: 2" MG 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.
Funeral Director: After this eted filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier npleted f (Check within 2 To the f Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D0070435 4/20/11 10x1 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Putel N charles 701 Evite 4105 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Christopher Migale	1- For Stat		ate of Maryla		artment of l		nd Ment	al Hygie		a No	Physical Control of the Control of t	1200
Physician Medical Examine	4	nt's Name (First, Midd Christo		-	Stocks			M	ate of Death	Day Year		ime of Death
	_		on, give street and num	_	4b	. City, Town, o Rosedale	r Location of		,	4c. County of Baltimore		
Funeral Director		ecurity Number 74 - 4452	6. Sex 7	7. Age (In yrs. la 29	ast birthday) Yrs.	If Under 1 Yes			Date of Birth	-81	9. Birthplac Foreign Country)	NV
the Maryland a or 28a-f show any tiffed at once.	10a. State	and Number	rles Elaine D	N	Town or Location			rrollt		g. Citizen of Wha	1 [Inside City Limits Yes 2XX No
ral", or items 23, other must be no	11. Marital 1 X Nev 3 Wid	Status er Married 2 M owed 4 Div	12. Was Dece	dent Ever in U. ces? 2 X No	If Yes 1 Y 16a. Decedent's	Decedent of Hi , specify Cuba les 2 X No Usual Occupa	ispanic Drigir n, Mexican, F o specify: ation (Give kir	Puerto Ricar	n, etc.)	14. Race - White,	etc.Afr nerio	
5-0036 ed within 72 hour tygene. other than "natu the Medical Exan Completed	Element 12t	ary/Secondary (0-12) h Grade s Name (First, Middle,	NA	4 or 5+)	-	t of working life k Driv	rer	,		J.B. Hi	unt (Company
21215 hould be file and Mental H is marked of tite event, til	M 19a. Inform	ichael	hip (Type, Print)	tocks	19b, Mailing A	ddress (Stree	Reg:			Desire	State, Zip (Qode) 1260.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hyggene. Important: If item 27 is marked other than injury or other traumantic event, the Medical To Be Comple	20a. Metho	d of Disposition	e-Mother	n State C	Place of Disposition crematory or other etro Cr	on (Name of ce	emetery,	Date 4-22-	e I	20c. Location - C	City or Town	, State
Baltin permit. P Departme Importar injury or	21. Signatu	ation 5 Other Spre of Funeral Service	Licensee		22. Nar Wi	ne and Addres	s of Facility	rown	Comm		Funei	nue cal Hom
Physician /Medical Examiner	Immediate or condition	Enter the disease, or List only one cause Cause (Final disease resulting in death) y list conditions, ing to immediate or Underlying Cause		cocaine consequence of	and amp					st, shock, or hear		proximate Interval tween Onset and Death
0, the executed sition and purial - transit edical Examine	(Disease of events resu	injury that initiated ilting in death) Last	c. Due to (or as a c		,	. 22 1	1	-				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execunwithin 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra edical Certification: To Be Completed by Physician/Medical		cedent pregnant in the	e 23c. If yes, ou	8a-1,pe itcome of pregn th nt at time of dea	r me,g91 nancy 2 Fetal	4-22-1 5,5-24- death 3	-11 sm	oregnancy	Th gy	23d. Date of de Month		Year
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tal Records, tian: The law requires certificate has been signetor, page 2 should be Be Completed	25 10/22 22					00 81			24a. Was an autopsy perform Yes 2	prid? prid		findings available etion of cause of
of Vital Rec Physician: The Leer this certificate Irral director, page	25. Was care examine 1 1 Y Y 27. Manner	es 2 No	Hospital: 1 Inp		ER/Outpatient 3 28b. Time of Inju	DOA DOA	of Death (C Other ₄ 1	Nursing Hom	ne 5 R	esidence 6		ne
Division of Vital Records, P.O. 24 hours after death. 24 hours after death. Pysician: The law requires that the 24 hours after death. Funeral Director: After this certificate has been signed by each filled in by the funeral director, page 2 should be detach: all Certification: To Be Completed by P.	1 Natr 2 Acc 3 Suid	ural 5 Pendident Investide 6 X Could	ing tigation 1 28e. Place of	ay,Year) 17-11 of Injury - At ho	fd 11:36 me, farm, street, f	am 1□`	Yes 2 X N	Unl	KNOWN.	reet and Number	or Rural Ro	ute Number, City i Hgwy
Di To the Hospital within 24 hours a To the Funeral I completely filled	4 Hor 29a. Certifie (Check only one)	T 1 Certifying Ph	ysiclan: To the best on iner: On the basis of and manner state	examination an	e, death occurred			e, and due to	the cause((s) and manner a	s stated.	
T s t s	N	le Joseph address of person	nd. Mo		220)	29c. Licens O.C.I			1	29d. Date signed April 18, 201		ay, Year)
State	Meliss	a Brassell, MD	who completed cause Assistant Medi 32. Fegi		er 111 Per	n Street, B	saltimore,	MD 2120)1			
Registrar		APR 22		444	has	and a						/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April ^{Day} 2011 Short, Sr. 18 5:17a Hurley Daniel Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4018 Lee Road Aberdeen Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🛛 M 2 □ F Months Days Hours 0272971932 79 Director Virginia 225-34-1266 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits Maryland Harford Aberdeen 1 XYes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 4018 Lee Road USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ٥ þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpentry Carpenter injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 McGlothlin Martha Jefferson_ Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 4018 Lee Road, Aberdeen, MD 21001 Sandra Bowman (daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State St. Paul Cemetery 4/21/2011 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. ister Maryland 21001 23a. Part 1. Enter the disease, or own plications that caused the death. Do not enter shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ApproxInak durati resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year 2 🗌 No g Unknown g Unknown P.O. ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed Hospital or Attending Physician: The 2 🗆 No 1 🗌 Yes Be (25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner' Hospital Other: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work? after death. Director: Aft Accident Investigation 2 Accident
3 Suicide
4 Homicide the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined building, etc. (Specify) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Sign 29c. License number 2011 10 30. Name and address of person who completed cause of death (Item 23a Type, Print) Robert 2627 Pulasti Jr. 6 Highway

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Month 2011 7.33 Baby Boy Sellmon Twin A Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Hospita The Johns Hopkins altimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth g. Birthplace (State or Foreign 1 X M 2 □ F Hours (Month Day, Year) pr 16, 2011 Director Maryland infant Apr Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Examiner must be notified 1 Ves 2 X No Ransom ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 28 Sparkling Brook Road 25438 USA items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or. Black, White, etc. þ 1 X Never Married 2 Amarried Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: "natural", black Completed 3 Widowed 4 Divorced Specify. Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ryan Sellmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 601 Wolfe Street Baltimore, Baltimore, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Survivisions Sicenses State Andromy a Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ xtreme prematurit disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter University Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Day g Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performed' 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 00 +009 and address of person who completed cause of death (Item 23a) (Type, Print) Wayock The Johns Huspital 600 N. h 21287 Hookins 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State 22 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Q Pri Baby Boy Sellmon Twin B 735 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPIta Baltimore Hopkins ohns If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Apr 16, 2011 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🗆 F Country) Maryland Hours Director infant Usual Residence of Decedent or 28a-f show filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits WV 1 ☐ Yes 2 ₩ No Ransom 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 28 Sparkling Brook Road 25438 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: black Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant. If item 27 is marked other than any or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Ryan Sellmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 601 N. Wolfe Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
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Important: If ite
any injury or ot
once. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 🗓 Other (Specify) in state Signatur of the late bicen wave, State and the subject of the state of the st 21201 Baltimore, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ xtreme Prematuri Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Lines underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗹 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident ☐ Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c License number 07009 and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins Wayouk he Johns 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 345 PM 04 Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death HOLAND MOBE **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Month Day, 19, 22, 1 **X** M 2 □ F Days Hours Min 218-28-8245 Director 79 Aŭĝ 1931 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3838 Roland Avenue #903 21211 USA items 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced 156-58 Specify: white Completed Year or Dates is marked other than "natur aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk unk 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. of Health and Mental Hygier item 27 is marked other to other traumatic event, the 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Strahler ALice Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Tom Matthews/cousin 3838 Roland Avenue #903 Baltimore, MD 21211 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō 1
Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🕅 Other (Specify) in state . Signature Fineral Sche Licensee State Anatomy Board 655 W. Baltimore Street Baltimore, 21201 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Osuse (Final Onset and Death Physician/ dUANCEO disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year been signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has incompleted filled in by the funeral director, page 2: autopsy performed?

Yes 2 No death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signature death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of CA State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 12204 Wood 7DM 2011 /Medical hevs buys VVu 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** nto . Age (In y a last birthday) Social Security Number **Funeral** Months Year) 1 □ M 2 □ Yrs. O Director 350-38-2474 July 20, Illinois 1907 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified a once. Director Gaithersburg 1 ☐ Yes 2√ No MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 333 Russell Avenue #620 20877 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: White Completed by 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ 12 housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Eugene Moore Clara Jane Wilkes ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9201 Wendell Street Silver Spring, MD 20910 Pam Silverwood/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∑ Donation 5 ☐ Other (Specify) Signatur Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca (Final disease or condition resulting in death) **Physician** ertrophic YPARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (unas a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burlar-transit completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Day 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 ☑No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl. one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 🗹 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of Atifier 29c. License number Date signed (Month, Day, Year) 2011 30. Name and address of person Russell Ave. Gaithersburg ever 31. Date filed (Month, Day, Year) State Registra

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year SAFIER DAVI 6.00 PM 01 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Rand Baltimore H030 Sex 1 M M 2 □ F . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) MD **Funeral** Min (Month 1 Day, Year) 2 2 Director 218-10-7235 88 Yrs. Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director 10d, Inside City Limits 1 Tes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8911 REISTERSTOWN ROAD 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 → Yes 2 → No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 - Widowed 4 - Divorced Year or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 OWNER INDUSTRIAL SUPPLIES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ JOSEPH SAFIER ROSE GOLDSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RANDY SAFIER/SON 2331 OLD COURT ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) OHEB SHALOM MEM. PARK: 04/21/2011 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Liganses 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset Death Physician/ disease or condition resulting in death) 0 Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine signed by the attending physician and defached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Completed page 2 should ber tension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? Yes 2 No the Hospital or Attending Physician: The I hin 24 hours after death. the Funeral Director: After this certificate h death? 2 🗆 No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes Other: 1 Ninpatient 2 🗆 ER/Outpatient 3 🗀 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Northwest AJAYSINGH HOO

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day MEIR STEINHARTER April 2011 10:38 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City, Town or Location of Death 4c. County of Death sinal Hospital of Balhmod Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/19/1911 Funeral Birthplace (State or Foreign Country) 1 🕅 M 2 🗆 F Days Hours Min 100 Director 215-24-3750 GERMANY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 10d. Inside City Limits 1 ¥ Yes 2 □ No MD N/A **BALTIMORE** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Skinbarke Funeral 3404 W. STRATHMORE AVENUE death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or iten 14. Race - American Indian, Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: Year or Dates WHITE Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15 Decedent's Education 16a. Decedent's Usual Occupation Meir 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Seconday (0-12) **TEACHER** EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Known as **BERNHARD** STEINHARTER JEANETTE **NEUHAUS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 3605 MENLO DRIVE, BALTIMORE. BERNARD STEINHARTER/SON MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Pahent 4 Donation 5 Other (Specify) CHOFETZ CHAIM CEM. 04/21/2011 ROSEDALE, MD urd of Funeral Se le Licenson Sign 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complice ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on ause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Acute myocardial Infarction 3 days Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed this certificate 1 ☐ Yes 2 ☐ No 2 No Yes 25. Was case referred to medical examiner? Be မ 1 ☐ Yes 2 ☑ No Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? ithin 24 hours after death.

the Funeral Director: A completed filled in by the fi 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Daula yshin - Tamasho April 20, 2011 RES - 000 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cecina Yshij-Tamashino, MD Sinai Hospital of Baltimore 32. Registrar's Signature State Registrar

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11-02330	riease Type of Frint in Black indelible link. Ensure All Copies Are Legible.	
Shawn Thomas Tares	State of Maryland / Department of Health and Mental Hygiene	1296
1. For State		

	1- For State Registrar		Cert	ificate of	Death			Reg	g. No.		
Physician/ Medical Examine	Sh	awn Thomas						Date of Death Month April 19, 20	Day Year		of Death 5 hrs
	4a. Facility Name (if not inst Snowden River Pa		-	4	o. City, Town, or Columbia	Location o	f Death		4c. County o	Death	
Funeral Director	5. Social Security Number 496 96 3445	6. Sex	7. Age (In yrs. las		If Under 1 Year Months Day			8. Date of Birth	1070	9. Birthplace (S	State or ISSOURI
	Usual Residence of Decede			Yrs.		<u> </u>	JJ	11/03/	1919		
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ath with the Maryland items 23a or 28a-f show ast be notified at once.	10e. Street and Number 6214 Wild Sw	an Way	_		10f. Zip Code 2104!	5	-	10	g. Citizen of Wha United	_	
Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Gant: Witem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2		ecedent Ever in U.S. Forces?		Decedent of His s, specify Cubar				14. Race - White	American India etc.	n, Black,
s after de real", or niner mu by Fu	3 Widowed 4	Divorced If Yes, Give Ye or Dates:	ear		res 2 X No					White	
2 hours after "natural", I Examiner	15. Decedent's Education Elementary/Secondary (0)		ade completed) 1 (1-4 or 5+)	16a. Decedent during mo	s Usual Occupat st of working life	tion (Give k . DO NOT t	ind of wor use retired	rk done d)	16b. Kind of Bus	iness/Industry	
5-0036 ed within 72 hour flygiene. to ther than "natt the Medical Exan Completed		5+		Resea	rch Scie				Federal	Govern	nent
215- be filed that Hyg rked oth ent, the	17. Father's Name (First, Mi Thomas Franc.						,	irst, Middle, Mi Camme	aiden Surname)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica.	19a. Informant's Name/Rela Angelica N.								per, City or Town		e)
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Physician /Medical	23a. Part I. Enter the diseas failure. List only one ca	use on each line.	caused the death. D	o not enter the	mode of dying,	such as ca	rdiac or re	espiratory arres	st, shock, or hear		kimate Interval en Onset and Death
Examiner	Immediate Cause (Final dis- or condition resulting in dea		a consequence of):								
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca		a consequence of):								
ted I Insit Examine	(Disease or injury that initial events resulting in death) L	ast Due to (or as	a consequence of):								
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Division o Biopital or Attending 24 hours after death. Funeral Director: Afte stely filled in by the funer al Certification:		ould not be	ce of Injury - At hom Woods	e, farm, street,	factory, office be	uilding, etc.	- 1	or Town, Sta	reet and Number ite) Parkway and		510.5
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transis Medical Certification: To Be Completed by Physician/Medical Ei	29a. Certifier 1 CertifyIn	g Physician: To the be Examiner: On the basis	of examination and								·)
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	20 Name and add		on of doub // 25	20)	O.C.N	И.E.			April 20, 201	1	
)	30. Name and address of pe Donna M. Vincenti	MD Assistant I	Medical Examir	ner 111 F	Penn Street,	Baltimo	re, MD	21201			
State Registrar		(ar) 32. R	egistrar's signature	and							

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Donald James Tho	1-	For State	Sta	ate of Maryla		artment o			l Mental F	łygiene	Reg. No.			1 2 3 0
Physician Modical Examine	/ 1 er	Decedent's Name. Dona1	d Jame	s Thomas						2. Date of D Month April 13,	eath Day	Year		3. Time of Death 1533 hrs
a de	4	a. Facility Name (if 1416 Hanso		n, give street and nu pt. 72	ımber)		4b. City, T Edgev		ocation of Deat	th		c. County of Harford	Death	
Funeral Director	5	. Social Security No	^{ımber} unk	6. Sex 1∭ M 2 F	7. Age (In yrs.	last birthday) 78 Yrs	Months	Pr 1 Year Days	If Under 24Hr Hours Min	_			Foreign	nplace (State or n unl ntry)
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene. Not: If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once. To Ba Completed by Firnaral Director.		Elementary/Secon		College (1					on (Give kind of DO NOT use re		k 166.1	Kind of Busi	ness/ir	unk
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Baltimore, oermit. Pages I and Department of Heal Important: If iten injury or other tra	1	Da. Method of Dispo Burial 2 Donation 5	Cremation	3 ☐ Removal fro	om State	Place of Dispos crematory or oth		e of ceme	etery,	Date	20c.	Location - (ity or T	own, State
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Physician /Medical Examiner	In	failure. List only nmediate Cause (F.	one cause of inal disease	omplications that can on each line. a. Atheroscler		n. Do not enter th	ne mode of	fdying, s	uch as cardiac	or respiratory a	arrest, sho	ock, or hear		Approximate Interval Between Onset and Death
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To the Hospi within 24 hou To the Fune completely fil		la. Certifier 1 C		rsician: To the best Iner:On the basis of and manner st	f examination a									
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State	4	Zabiullah Ali, Date filed (Month,	Day, Year)		gistrar's Signatu			, baitim	nore, MD 21	ZUT				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year Raymond David Utz 343A M Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hos BAUTIMONE 6. Sex **U** 1**X** M 2 \square F Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 10-19-1946 213-46-4579 Months Days Hours Director 64 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Carroll Hampstead 1 🗌 Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 44 N. Houcksville Rd. 21074 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Completed by should be filed within 72 hours after 1 ☐ Yes 2X No Specify: "natural" 3 Divorced 4 Divorced Specify: white Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Quality Tool Control Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental I Raymond M. Utz Florence Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Utz-wife Page 1 and 2 Houcksville Rd., Hampstead, MD Baltimore, Important: If item any injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State South Carroll Crem 4-22-11 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign at a of Funeral Service Lio 22. Name and Address of Facility Fletcher Funeral Home + lahlu 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pulmonom e Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 9 Unknown 2 No 4 ☐ Pregnant : 9 ☐ Unknown has been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 No 1 Yes 25. Was case reasoner?
1 Yes 2 Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 100 မှ 1 Impatient 2 I ER/Outpatient 3 I DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 me and address of person who completed cause of death (Item 23a) (Type, Print) Since Itospital & Bultsure 2401 W. Belvider 21200 Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. 2:30A 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Westminster Carroll Hospice Dove House arrol 5. Social Security Number If Under 1 Year . Age (In vrs. last birthday) If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Months 9-21-1936 MD Country) 214-34-4243 Director 74 Usual Residence of Decedent 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits notified MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 2029 Old Taneytown Rd. 21158 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. ğ 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinery Millwriaht 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James E. Wood Mathilda Windisch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Cooney Wood-wife 2029 Old Taneytown Rd., Westminster, MD Department of Health Important: If item 2 any injury or other t other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-22-11 Finksburg, MD Evergreen Mem. 4 Donation 5 Other (Specify) Signature Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral tionas 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury Physician/Medical Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day 9 Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No neral Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on and title of certifie 29b. Signatu . Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 Center 1 uter

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar	ryland		rtment of F		ınd M		711		1290	54
			Registrar 1. Decedent's Name (First, Middle, Last)			Cert	incate of L	Jean		2. Date of Dea	Reg. No.		1 (44 67	
	Physicia		Doris Evelyn	Watkins						Month April	Day 18	Year	3. Time of [
and the last	Medic Examin		4a. Facility Name (if not institution, give str			T	4b. City, Town, or	r Location of		ADITI		2011 ty of Death	1:10	P ^M
			Holy Cross Hospit	cal			-	Spri				tgome:	rv	
	Funeral		Social Security Number 6. Sex		in yrs. last	t birthday)	If Under 1 Year Months Days			8. Date of Birt	h	9. Birthp	place (State or	Foreign
	Director		219-12-4003	M 2X F	87	Yrs.	Months Days	Hours]	May 24	, Year) 1923	Mar	yland_	
	how at	=	Usual Residence of Decedent 10a. State 10b. County		0c. Citv. 1	Town or Loca	ation			_		1	0d. Inside City	Limita
	arylar a-fs ified	Director	MD Prince Ge									1	1 V Yes	
	or 28 e not	늅	10e. Street and Number	orge s	11 9 6	attsvi	10f. Zip Code				10g. Citizen of	What Coun		
	with s 23a ust b	Funeral	5812 31st Avenue	9			20782	2			_	USA	,	
	death items er m	핊	11. Marital Status	2. Was Decedent Eve	er in U.S.	13. W	as Decedent of H Yes, specify Cuba	ispanic Origii	in? (Speci	ify Yes or No-	14. Ra	ce - Americ	an Indian,	
36	", or	þ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give	0		Tes, specify Cuba		Puerto Ri	ican, etc.)		ack, White, e		
Ö	ours a	Completed	3XXWidowed 4 □ Divorced	Year or Dates.							Specif	Wh:	ite 	
Ϋ́	72 h n "na Medic	npl	15. Decedent's Educ (Specify only highest grade	completed)		(Give kii	ent's Usual Occup and of work done of NOT use retired)		of working	g	16b. Kind of I	Business Inc	dustry	
212	vithin jiene. sr tha the t		Elementary/Seconday (0-12)	College (1-4 or 5+)			memaker				Own	Home		
b	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	7				18. Mother	's Name ((First, Middle, I	Maiden Surnan			
<u>Ja</u>	d be Menta arked atic e	입	Vernon Earl Duv	all				Maı	ude 1	Bell Mu	isgrove			
Maryland 21215-0036	should be file and Mental I is marked o raumatic eve		19a. Informant's Name/Relationship (Type	, Print)		19b. Mailing	Address (Street a	and Number	or Rural F	Route Number	; City or Town,	State, Zip C	Code)	- 1
<u>~</u>	of and 2 should be in the set of Health and Ments fitem 27 is marked rother traumatic e		Elwood Earl Watkin	s/Son		112	Emilys F	intai	l Dr	ive, Br	idgevi	lle, I	DE 199	33
Baltimore,	Page 1 a ment of H ant: If ite ury or ot		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re	emoval from State	cem	netery, crema	tion (Name of atory or other plac	e)	Da	nte	20c. Location	- City or To	wn, State	
ţ	tt. Pag rtmer rtant rjury		4 Donation 5 Other (Specify)		Unic	on Cem				/2011	Burto			
Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	0 - 2/	01103		Name and Addres 3 Talbot		DOI		Funer	al Hor 2070		١.
			23a. Part 1. Enter the disease, or complic	ations that caused th								2070	Approximate	
-2.	Ph_sician/		Immediate Sause (Final	caus on each line. Pneur									Interval Betwee	een
	Medical		disease or condition resulting in death)	Due to (or as a co								-	Days	
	Examiner	<u>.</u>	Sequentially list conditions, b.	Demer	ntia									
	p #	nine	if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequen	nce of):								
96	ecute and I-trans	zxar	that initiated events c. resulting in death) Last	Due to (or as a co	onsequen	ice off:								
_	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner		(
09/	icate g physis the	ledi	d.											
200	certif inding use a	<u> </u>	IF FEMALE: 23b. Was decedent pregnant	. If yes, outcome of	pregnancy						23d D	ate of delive	erv	
POX	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐XNo	1 Live Birth 2 4 Pregnant at tir			Ectopic pregnanc Other (specify)	У					Day Yea	ar
	that the ned by the detache	Physician/Me	g Unknown	9 Unknown										
, О	ss tha igned be de	۵	Part II. Other significant conditions control Ischemic Coli-		not resultii	ing in the und	derlying cause giv	en in Part I.			bacco use con			
<u>5</u>	v require s been si should	ete								1 L Y	es 2 No	3 LJ Prob	ably 4LAAUr	ıknown
ပ္တို့	has t	Completed	Hypothyroidis	m						24a. Was a autops	sy	prior to con	sy findings ava npletion of cau	
ř	r: The ficate r, pag		OF Man annu vafawani ta madiani							performula 1 Yes	2 No	death?	2 X No	
<u> </u>	siciar certii irecto	1	25. Was case referred to medical examiner? 1 Yes 2 XNo	spital: 😮				ace of Death	,	,,				- '
2	y Phy er this eral d	e: 10	27. Manner of Death	1 Inpatient 28a. Date of injury	28	b. Time of	3 L DOA 28c. Injury	4 L Nurs			ence 6 Othow injury occur			
Division of Vital Records,	ath. r: Afte	icat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Ye	ear)	injury	M 1 🗆	? Yes 2□N	- 1		,,			
	r Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	- At home	e, farm, stree	t, factory, office		28	If. Location (St	reet and Numb	er or Rural i	Route Number	;
5 ;	urs afi ral Di lled in								11	City or Town				
:	Hosp 24 ho Fune sted fi	Medical	29a. Certifier (Check 2 Medical Examiner	On the basis of exam	nination an	nd/or investig	ation, in my opinio	n, death occu	urred at th	e time, date an	d place, and du	e to the cau	se(s) and mann	er stated.
	to the Neoptial or Attending Physician: the law requires in the law requires in the Law requires and the Law result of the Law ster death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	— r	only one) 3 L Certifying Nurse F 29b. Signature and title of certifier	ractioner: To the bes	st of my kn	nowledge, dea	ath occurred at the 29c. License	time, date ar	nd place,	and due to the	cause(s) and m	anner as sta	ted.	
	~ S ~ O		Muhum	a			D32				April			
	10	ŀ	30. Name and address of person who com	pleted cause of death	h (Item 22	la) (Tyne Pri						, 2		
	()		Suresh K. Gupta				Avenue,	Suite	2-20	, Sil	ver Spr	ina.	MD 2090	02
	State		31. Date filed (Month, Day, Year) APR 2 2 2011	32. edistrar's	Signature	La								
	Registra	7	MER Z Z 7/11.		IA.	A 40	40. 1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Wong Irene 11:55 PM Medical Apri1 2011 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number Date of Birtri (Month, Day, Year) 0 1931 **Funeral** Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 - XT F Months Days Hours **Director** Yrs 212-28-6372 79 Maryland Nov. Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified MD Harford Darlington 1 Yes 2 X No 10e. Street and Number 9 10f. Zip Code .s 23a o (must b 10g. Citizen of What Country? Funeral 4041 Conowingo Rd. Lot#31 21034 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 Yes 2 No ō þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced Specify White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Saunders Marie injury or other traumatic Constance Amendt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Gail L. Nosbaum / Daughter 4041 Conowingo Rd. Lot#31, Darlington, MD permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4XXDonation 5 Other (Specify) Uniformed Sers, Univ. 4/21/2011 Bethesda, MD Signature of Funeral Sen Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition CONGESTIVE HEART FAILURE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Due to (or as a consequence on Exami burial-transi Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical death certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ó in the past 12 months?
1 Yes 2 No Month signed by the at Id be detached for Pregnant at time of death Day Year g | Unknown g Unknown P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Completed 1 Tyes No 3
Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate perform 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) HOSPICE funeral n 24 hours after death.

The Funeral Director: After the pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No M ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2. 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 201

Registrar
DHMH 17 Rev 7/2009

State

JACKIE

JONES,

CRNP

2011

MARY WONG

TIMONIUM,

MD 21093

2300 DULANEY VALLEY RD.

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Ma	aryland / Depa <i>Cei</i>	artment of F			giene Reg. No. 0	1 12966
	Physicia		1. Decedent's Name (First, Middle, Last) Barbara M. Wright				2. Date of Dea	ath	3. Time of Death 7:15 PMM
	Medic Examin		4a. Facility Name (if not institution, give street and number) Manor Care Falls Road		4b. City, Town, or Balti			4c. County of	
Ī	Funeral Director		220-42-6640 1 □ M 2 🌣 F	(In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th y, Year) 1943	9. Birthplace (State or Foreign Country) Rhode Island
	/land f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	r 28a- notifie	Funeral Director	MD 10e. Street and Number	Balti	more			10g. Citizen of Wh	1 ▼ Yes 2 □ No
	s 23a c	eral	4669 Falls road		1 '	21209		0	JSA
929	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. It of Health and Mental Hygiene. Or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced 12. Was Decedent E Armed Forces? 1 ▼ Yes 2 □ If Yes, Give Year or Dates.	ver in U.S. 13. \	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🏻 No		Specify Yes or No- rto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. black
Baltımore, Maryland 21215-0036	ithin 72 hou ene. • than "natu he Medica	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	(Give i	dent's Usual Occup kind of work done o O NOT use retired) upervisor	during most of w	orking	16b. Kind of Busi	ness Industry
land 2	l be filed w fental Hygi rked other tic event, t	To Be	17. Father's Name (First, Middle, Last) Anthony J. Soares		uper visor	18. Mother's N	ame <i>(First, Middle,</i> istine Me	Maiden Surname)	eater
, Mary	id 2 should salth and N n 27 is ma er traumai	ì	19a. Informant's Name/Relationship (Type, Print) Cecelia Hargrove/daughter	19b. Mailir 2912	ng Address (Street a Sylvan A	and Number or R venue Ba	altimore,	r, City or Town, State	
Imore	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	e)	Date	20c. Location - C	ity or Town, State
Balt	permit. Page Department or Important: If any injury or once.		21. Signature of Frincial 11 e Licentina de Dire		StatendAdda Baltimore	-	ard 655 W .201	. Baltimo	ore Street
P	nysician	6 //	23a. Parl 1. Enter the disease, or complications that caused shook, or heart failure. List only one cause on each line Immediate Sause (Final disease or condition	_	er the mode of dyin	g, such as cardia	c or respiratory arr	rest,	Approximate Interval Between Onset and Death
المرسية	Medical Examiner	L	resulting in death) Due to (or as a Sequentially list conditions, b.	consequence of):					
	nd ransit	dical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	consequence of):					
20	hysician a	dical E	resulting in death) Last Due to (or as a	consequence of):					
. Box 687	To the hospital or Attending Frigstrant, the law requires that the beart continued be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	≥ ☐ Fetal death 3 ☐	Ectopic pregnanc	у		23d. Date Month	
IS, P.O.	n signed by	ed by PI	Part II. Other significant conditions contributing to death but Ray Fas	it not resulting in the u	nderlying cause giv	ven in Part I.			ute to the cause of death?
Vital Records,	ite has bee age 2 shou	Completed					24a. Was a autop perfo	osy prio	re autopsy findings available or to completion of cause of ath?
	ertifica ector, p	Be	25. Was case referred to medical examiner?			ace of Death (Ch		2 110 12	100 2 100
א זס ה	th. After this o	cate: To	1 Yes 2 No Hospital 1 Inpatie 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	nt 2 ER/Outpatien / 28b. Time of injury	28c. Injury work	4 Nursing / at		lence 6 Other (Specify)
DIVISION	s after dea:	Certificate:	3 Suicide 6 Could not be	y - At home, farm, stre (Specify)			28f. Location (S City or Tow		or Rural Route Number,
- :	in 24 hours in 24 hours he Funera pleted fille	Medical	29a. Certifier 1 Certifying Physician: To the best of r (Check only one) 3 Certifying Nurse Practioner: To the basis of ex	amination and/or invest	igation, in my opinio	n, death occurred	d at the time, date a	nd place, and due to	the cause(s) and manner stated.
	With Tot		29b. Signature and title of certific	MD	29c. License	06931	4	29d. Date signed (A	1/2011
			30. Name and address of person who completed cause of de	ath (Item 23a) (Type, P Waltham 's Signature	woods	Pa, Pa	1-V1/1R	MD 2	1234
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registral	's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MIRIAM YAGERMAN APRIL 2011 08:29P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ENVOY OF PIKESVILLE PIKESVILLE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Hours Min (Month, Day, Year) 10/15/1913 97 Yrs. **Director** 217-09-2061 MD Usual Residence of Decedent oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ី No MD BALTIMORE BALTIMORE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 32 FENCEPOST COURT 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Completed Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ CHARLES GORDON REBECCA FELDMAN 19a. Informant's Name/Relationship (Type, Print) 1 and 2 shound Health and item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, IRIS GRABUSH / DAUGHTER 6300 RED CEDAR PLACE, #403, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite Date 20c. Location - City or Town, State MTKRO, crematory or other place) BETH ISRAEL 1 🔀 Burlal 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 04/21/2011 BALTIMORE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. any 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) 1 emen 129V-J Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fetopic pregnancy in the past 12 months? 4 Pregnant 5 Other (specify) Month Dav Year Pregnant at time of death the a g Unknown Division of Vital Records, P.O. ed by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Slingles Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 certificate has performed Yes 2 1 Yes 2 No Be 25. Was case referred to medical director 26. Place of Death (Check only one examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2ga. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie

Registrar

State

K

Charles

St Suite 4105 Towson MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(cmo

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32. Registrar's Signature

Juson Blac

31. Date filed (Month, Day, Year)

PR 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20// -1. Decedent's Name (First, Middle, Last) Date of Death Month Physician John E. Zacot 11705AM /Medical April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Genesis Perring Parkway Center

5. Social Security Number 6. Sex 7. Age (In Baltimore, Maryland Bultimore If Under 1 Year If Under 24 Hfs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) West Virgini 7. Age (In yrs. last birthday) **Funeral** 1 **X**M 2 ☐ F 234-40-3013 **Director** 83 June26,1927 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mential Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the healts I event in at the notitied at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ar than "natural", or items 23a or 28a-f show the Medical Exactions to ust by notified at Baltimore MD Director Middle River 1 Tyes 27 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Yawmeter Drive 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 TXNo Specify: ģ Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Elementary/Secondary (0-12) College (1-4or 5+) 4yrs Government Logistics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Burzy F. Zacot ပ Vida M. Wamsley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Zacot Jr. /son 3423 Hamilton Avenue Balto. MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1 Burje / 2 Cremation 3 Removal from State Holly Hill Cemetery 4/23/11 4 ☐ Donation 5 ☐ Other (Specify)

21. Sign turn if Fureral Service Lice ee Baltimore MD 22. Name and Address of Facility 300 Mace Ave. Balto. MD Willia Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Stage Liver Cancer with ascites disease or condition resulting in death) months /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence on The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnancy Year 4 ☐ Pregnant at time of death Day P.O. I 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Atheroslerotic Cardiovascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy Recurrent Gastrointestinal Bleeden performed 1 ☐ Yes 2 ☐ No 1∐Yes 2∭ENo or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Nurse Practitioner. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) michelle E. Kalendek CRNP R097104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle E. Kalendek, CRNP 1801 Wentworth Rd. Baltimore, Maryland 21234

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 5,2011 Year Rosario Bonilla Ardon 12:40pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Rockville **Examiner** County of Death
Montgomery Casey House Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛭 F 578-80-8998 Months Days Hours Min 1914, Pay, Year) Director $\mathtt{EI}^{^{\mathcal{C}\! ext{ountry}}\! ext{Salvador}}$ Usual Residence of Decedent 28a-f sho State 10b. County the Maryland must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George' Hyattsville 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? Funeral with 238 5805 Chillumgate Road 20782 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or Nothe Medical Examiner 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
El Sal Vadoran Black, White, etc. White 1 Never Married 2 Married 9 δ Baltimore, Maryland 21215-0036 1 XYes 2 ☐ No Specify: "natural", 3 Divorced 4 Divorced Completed Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Health Aid 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital is marked other Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) 2 Roberto Monterrosa Alicia Ruiz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blanca Bonilla/Daughter 8502 Cunningham Dr.College Park, Md.20740 20b. Place of Disposition (Name of cemetary, crematory or other place)
Jardines Del Recuerdo San Salvador, El Salvador Date 1 X Burial 2 Cremation 3 X Removal from State 4/11/2011 4 ☐ Donation 5 ☐ Other (Specify) ne al Service Dicerki 21. Signature PHILIPAD SRIMALDI FUNERAL SERVICE, P. A Moset 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician, Onset and Death Respiratory failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Fibrosing alveolitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ing physician and e as the burial-transit Examine Daw to for as a nonsequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be deteched for use as the burlar-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Pulmonary hypertension Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 XNo 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Y Other (Sphip) Spice Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident 2 🗆 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and fitle of certifie 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborah Muncaster Mill Rd Rockville, Md 20855 Miller CRNP 6001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 07 2011 Registrar

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			for State	tate of Marylan				Mental Hy	giene 20	1 12970	
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	n with the	neral D	10e. Street and Number 2211 Washington Av	e Apt 201		10f. Zip Code 20910)		10g. Citizen of What USA	at Country?	
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	वि	Never Married 2 Married	Vas Decedent Ever in U.S Armed Forces? 	l I	Vas Decedent of H i Yes, specify Cuba	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black,	American Indian, White, etc. White	
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Baltimore,	. Page 1 a trent of H tant: If ite jury or oth		20a. Method of Disposition 1 ☐ Burial 2 🏻 Cremation 3 ☐ Remode 4 ☐ Donation 5 ☐ Other (Specify)	oval from State Nat	lace of Disposemetery, crem ional	sition (Name of latory or other place Cremator	ÿ 04,	Date '02/2011	20c. Location - Cit		
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Divi	pital or A ours after eral Direc filled in by								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 (completed filled in by the funeral director, page 2 (completed filled in by the funeral director).	Medical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: Or Only one) 3 Certifying Nurse Prace 29b. Sanature and title of certifier	the basis of examination	and/or investig	gation, in my opinio	n, death occurred time, date and plant	at the time, date ar ace, and due to the	nd place, and due to cause(s) and manne	the cause(s) and manner stated. r as stated.	
9			Jam of Son		OME	29c. License	5+28		Page 1	onth, Day, Year)	
			30. Name and address of person who completed the state of	SER, mo	Ont	nt) 52 5 3/1	y Ha	WK Py 6	mb 2	690f	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State AMEND#8 Per FH State Of Ivial year State Of Ivial year Registrar 4/8/2011 AACO HFALTH DEPT (MH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL MARLENE MARTHA ALLISON 1750 P ^M Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL Social Security Number If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F 1939 05711719 NEW YORK Director 056**–**32–3964 Yrs Usual Residence of Decedent 28a-f show 10a. State with the Maryland notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND 1 ☐ Yes 2 🛣 No ANNE ARUNDEL ANNAPOLIS ò 10e. Street and Number 10f. Zip Code must be 10g. Citizen of What Country? Funeral items 23a 930 MARCONI AVE 21401 USA 72 hours after death Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner ò 1 Never Married 2 Married 2 XNo þ 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3X Widowed 4 ☐ Divorced Specify: WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) filed within College (1-4 or 5+) n and Mental Hygien 7 is marked other t OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DONALD CUPP traumatic HORTENSE LANG permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 2 any injury or other t LISE SUTTON/DAUGHTER CHESTER, MD 21619 306 SUNSET ROAD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATION 04/08/2011 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) STEVENSVILLE. . Signa Juneral Service 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ne cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Due to (or as Medical resulting in death) onsequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of) if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury that initiated events signed by the attending physician and Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: ပု within 24 hours after deau.

To the Funeral Director: After this and annihited filled in by the funeral di 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b, Signati and title of of 29c. License number 376 ned (Month, Day, Year) 201/ n who completed cause of death (Item 23a) (Type, P 00 31. Date filed State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rache1 Αм Adkins 2011 7:00 Medical Amν 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Atria Assisted Living Salisbury Wicomico Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 👿 F Months Days Min. Hours 3-9-192 Country)
Marvland Director 216-12-1842 89 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d Inside City Limits Examiner must be notified 1 ☐ Yes 2X No MD Wicomico Salisbury ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1110 Healthway Drive 21804 USA items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black White etc 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give "natural", 3 ₺ Widowed 4 □ Divorced Specify: Completed Year or Dates White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Norman Twillev Amv Adkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21849 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Raymond Adkins - Son 32825 Mt. Hermon Road, Parsonsburg, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Pk.: 4-7-2011 Salisbury, Maryland gnature Funeral Service License 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Interval Between Immediate Cause (Final Onset and Death AMoursyprohi cardiorneglandisease Physician/ disease or condition resulting in death) Medical Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year the detached Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 5/21/03/16 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 ≥ No certificate 1 Yes 2 A funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ျ 4 Nursing Home 5 Residence 6 YOther (Specify) 4551 GIVIU 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practionar: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge, death coourned at the time, date and place, and due to the cause(e) and menner as stated 29b. Signature and title of certifier D 32014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 166 Milfor St Toy & salishing mp 7/804 Mallery WithANA 31. Date filed (Month, Day, Year) gistrar's Signature State Registrar

Medical Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed attending physician Box 68760 ō signed by the a d be detached for P.O. Records, should of Vital director, To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di Division

filed within 72 hours after death with the Maryland

al Hygiene. I other than "

2 should be file h and Mental H 7 is marked ot

Maryland 21215-0036

Baltimore,

State

31. Date filed Month, Day, Year) 32. egistrar's Signature 2011 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NiMag

29b. Signature and title of certific

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29d. Date signed (Month, Day, Year)

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1-		-	State Registrar	Cer	tificate of Death		Reg. No.		
0.	Physici Medi	cal	1. Decedent's Name (First, Middle, Last) Beulah Bresler			2. Date of Dea Month April	03, 2011 Year	3. Time of Death 1707 M	
5	Exami	ner	4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospita	ıl	4b. City, Town, or Location Rockvi		4c. County of Dea	ntgomery	
=	Funeral Director		5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex 1 □ M 2 ☑ F 87	last birthday)	If Under 1 Year If Under Months Days Hours		h 9. Bi	thplace (State or Foreign	
ن			Usual Residence of Decedent	ty, Town or Loc		1 11/20	11925 300		
A	Marylan 28a-f sh etified a	recto	Maryland Montgomery	ty, Town or Loc	Rocku	ille		10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
- 5	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?		
201	death w items (11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of Hispanic Orion Yes, specify Cuban, Mexicar		14. Race - Ame		
()	15-0036 72 hours after a "natural", or ledical Exami	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates.		☐ Yes 2 No Specify:		Black, Whit	e, etc. White	
23	15-0 72 hour n "natu Aedical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation ind of work done during most ONOT use retired)	t of working	16b. Kind of Business National		
9	212 Within ygiene.		Elementary/Seconday (0-12) College (1-4 or 5+)	iire. Do	Editor		of Scien		
11/26	and be filed ental Hy ked otl	To Be	17. Father's Name (First, Middle, Last) 1. Stael Seide		18. Mothe	er's Name (First, Middle, i Fan	Maiden Surname) NY KATO		
`	Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam.		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Numbe	er or Rural Route Number	City or Town, State, Zi		
	Te, N 1 and 2 of Health item 2 other t	П		Place of Dispos	E. Emerson Av	enue, Lexing	3ton, MA 02 20c. Location - City or		
-5	Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Ponation 5 □ Other (Specify) B' N	lai Isr		04/05/2011			
	Ball permit Depar Impor any ir		21. Ignal re of Funeral Service Li ensee H0009	11 1	Name and Address of Facilit 800 New Hamps I	∀Hines-Rina hire AveS	ldi Funeral ilver Spriv	Home, Inc. La.MD 20904	
r, Bendah	Private and panual factor and panual factor and purial factor fac	Examiner	23a. Part 1. Enter the disease, or complications that caused the deat shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions) Due t	uence of):	r the mode of dying, such as		est,	Approximate Interval Between Onset and Death	
00	or Attending Physician: The law requires that the death certificate be explared earth certificate be explared earth certificate be explared earth certificate has been signed by the attending physician in by the funeral director, page 2 should be detached for use as the burian	/Medical	d. FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live Birth 2 Feta 4 Pregnant at time of constitutions 9 Unknown 9 Unk	ıl death 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year	
1	S, F.S. res that signed!		Part II. Other significant conditions contributing to death but not res	ulting in the ur	derlying cause given in Part I		bacco use contribute to	the cause of death?	
	ecords	Completed by	Acute renal failure	,		24a. Was a	n 24b. Were au	topsy findings available	
9	Ital Ke(ician: The la certificate ha ector, page		SEVERE A ortic sten			perfor	med? death?	s 2 🗆 No	
	hysicia hysicia this cert	To B	examiner? 1 ☐ Yes 2 🔀 No Hospital: 1 🔀 Inpatient 2 ☐		3 DOA Other: 4 Nu	h (Check only one)	ence 6 Other (Spec	ify)	
	on on on on on on on on ath. T. After to funerate funerate.	icate:	27. Manner of Death 1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	28b. Time of injury	28c. Injury at work? M 1 \(\sum \) Yes 2 \(\sum \)	I	w injury occurred		
	DIVISION OF VICAL RECORDS, tal or Attending Physician: The law requires rs after death. The lamb Director After this certificate has been signed in by the funeral director, page 2 should be	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At ho building, etc. (Specify,		et, factory, office	28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,	
•	To the Hospital or Attending Physician: within 24 hours after death within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	क ।	29a. Certifier 1 Certifying Physician: To the best of my knowl (Check 2 Medical Examiner: On the basis of examination	and/or investig	gation, in my opinion, death oc	curred at the time, date an	d place and due to the	cause(s) and manner stated	
	To the I within 2 To the δ Complei		only one) 3 Certifying Nurse Practioner: To the best of my 29b. Signature and title of certifier	knowledge, de	eath occurred at the time, date 29c. License number	and place, and due to the	cause(s) and manner as	stated.	
	5		Mant Snot	ins	D00644	413	April 03,	2011	
_			30. Name and address of person who completed cause of death (Item Juanita Lynn Smith, M.D., 9901	Medica	al Center Driv	ve, Rockvill	le, Marylar	d 20850	
	Stat Registra		APR 06 2011 31. Registrar's Signar	are face	led.				

State of Maryland / Department of Health and Mental Hygiene' State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month Ester R. Baxley March 31 Medical 19:40 PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Cheverly **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug . 1.2 9. Birthplace (State or Foreign Country) Alabama 1 □ M 2 🗗 F Months Days Hours Min 85 1925 Director 420-34-5518 Usual Residence of Decedent shov at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified 28a-f Washington 1 X Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 718 Parkside Place NE 20019 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Completed by Black, White, etc. "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Divorced Black Specify: Year or Dates and Mental Hygiene.

is marked other than "natur
aumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) 12th Nurse Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be James Brasher Annie Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, ge 1 and 2 sh it of Health a if item 27 is Bridgette B. Baxley - Daughter 718 Parkside Place NE Washington, DC 20a. Method of Disposition Page 1 2 20b. Place of Disposition (Name of 20c. Location - City or Town, State b 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Department Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 2011 Brentwood, Maryland 21. Signature of Fugeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death C7 ram Immediate Cause (Final evenua Physician/ disease or condition resulting in death) Medical Due to (o) as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. achexia attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Day Year g 🗌 Unknown Division of Vital Records, P.O. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsy After this certificate h 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: မ 1 🗌 Yes 2 110 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending n 24 hours after death Accident Investigation 1 Tes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 3/12011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive Cheverly, Maryland 20785 31. Date filed (Month, Day, Year 32. Registra APR 0 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> Physician/ Janet Evanne Bernardo March 31 11:39 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Days (Month, Day, Year) Months Hours Min. 177-34-9036 Director Pennsylvania March_ Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 √ Yes 2 □ No Maryland Montgamery Montgomery Village 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 19108 Brook Grove Court 20886 U.S.A. items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) filed within 72 tal Hygiene. Elementary/Seconday (0-12) System Development Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental H is marked of Edwin R. Emery Sallie McCready 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Lynn DuHuff (Sister) 106 Noble Drive Brookhaven, MS 39601 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Beltsville, Maryland Chesapeake Crematory 4/2/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home Signatur of Funeral Service Licensee 9013 Annapolis Rd. Lanham, MD 20706 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one eause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Breast Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Metastasis to brain Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burlal-transit Cause (Disease or liniury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Day Year been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Metastasis to spine Division of Vital Records, Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 🗌 No 1 Tes director, 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1- Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of xamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To byet of my knowledge; death assumed at the time, date and place; and due to the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21726 March 31. 2011 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Charles W. Karesh 26033 Ridge Rd. Damascus, MD 20872 31. Date filed (Month, Day, Year) State APR 0 6 2011 Registrar

Patient Known as Anthony Blake

		State of Maryland / Dep		•		
		1 - State C6	ertificate of Death		. 20 I	129//
Physicia Medio		1. Decedent's Name (First, Middle, Last) Anthony Blake		2. Date of Death	Day Year ZOI	3. Time of Death OU:53 AM
Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
Funeral		5. Social Security Number UNK 6. Sex 7. Age (In yrs. last birthday)	Baltimore City If Under 1 Year If Under 24 Hrs.	8. Date of Birth	I o n	the last Other State of the last of the la
Director		1 🖾 M 2 🗆 F 37 Yrs.	Months Days Hours Min.	1/23/1	974	rthplace (State or Foreign ountry) DC
land show	tor	10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits
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and 21215-0036 e filed within 72 hours after death with the Maryland tall Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fur	I Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
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212-	Con		DO NOT use retired) es Representati	ve	Private	
0 2 2 0	To Be	17. Father's Name (First, Middle, Last) Frankie R. Blake	18. Mother's Nam	ne (First, Middle, Ma	aiden Surname)	
Maryl should hand Me 7 is marl			ing Address (Street and Number or Run 37th St. SE #20			p Code)
0, E & E E		20a. Method of Disposition 20b. Place of Dispo				
Page 1		1 Burial 2 Cremation 3 Removal from State cemetery, cre.	matory or other place) Le Park Cre4/11	1	0c. Location - City or	
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other		21. Signature of Faneral Service Licensee	2. Name and Address of Facility DL 019 MLK Jr Ave	McLaug	hlin Fur	neral Home
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require	eted	Non-ischemic cardiomyopathy, Congestive hea	it tailore,			robably 4 🗆 Unknown
vital necords, ysician: The law requires is certificate has been sig director, page 2 should b	Completed by	Hypertension		24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
sician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inputient 3 ☐ FR/Outpatien	26. Place of Death (Check			
g Phys er this eral di	و: :e:	27. Manner of Death 28a. Date of injury 28b. Time of	nt 3 □ DOA 4 □ Nursing Ho 28c. Injury at	me 5 Residence 28d. Describe how	ce 6 Other (Specification)	ify)
eath. or: Afte	licat 	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	work? M 1 ☐ Yes 2 ☐ No	200.000.000	injury coodined	
al or Attending Pr safer death. In Director: After the ad in by the funeral	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, strubuilding, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
e Hospit n 24 hour ne Funera	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invest only one) 3 Certifying Nurse Practioner: To the best of my knowledge, cathodoxidate in the basis of examination and/or investigation.	tigation, in my opinion, death occurred at	the time date and r	place and due to the	cause(s) and manner stated
To ti with To ti		29b. Signature and title of certifier MD, Ph D	29c. License number	290	I. Date signed (Month	n, Day, Year)
	1	30. Name and address of person who completed cause of death (Item 23a) (Type, P	Print)		V/-	- 11
State		31. Date filed (Month, Day Year)	ital of Baltimore			
Registra		APR 0 6 2011 Ceneral D. Janes				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Shirrell Alita Bradford Medical 30 0040 A March 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince George's Hospital Center Cheverly 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Country) (Month, Day, Yea 578-98-1236 Director 40 July Usual Residence of Decedent show 10a. State ıral", or items 23a or 28a-f sho I Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Temple Hills 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4525 Dallas Place, #Tl 20748 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates. Š 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 Black 1 Yes 2X No Specify. "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Manager Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 0 James Bradford Carolyn Patricia Pryor permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4633 Dallas Pl., #201, Temple Hills, MD 20748 Carolyn Jackson - Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🛭 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crem. 4-11-2011 Riverdale Park, MD Sign of re of Funeral Service 22. Name and Address of Facility J. K. Johnson Funeral Home, P. A. ud of Ave., Temple Hills, MD 20748 Old Branch Fart 1. Enter the disease, of cabook, or heart failure. List on mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed VINAV and the burial-tran Due to (or as a consequence of resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ A carte tubular necrusis Completed 1 ☐ Yes 2 🗗 No 3 ☐ Probably 4 ☐ Unknown peen SEPTIC SHOCK 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed After this certificate MORBID OBESITY 2 🗌 No Yes _2 M No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 40 Certificate: To 1 🗌 Yes 1 Hinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, W DOD43662 march 30, 30. Name and address of person who completed cause of death (Item 23a) (Type, Pyin VIMAM BUYCE P & Hori

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Yea

6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4 Day 8 Bettie Lee Baker 11 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death
Baltimore Gilchrist Hospice Care Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign 1 □ M 2X F Months Days Director 579-20-8814 8 - 31 - 1 924 86 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2X No 23a or 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 10606 Hickory Crest Lane 21044 United States items death 1 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes X No Specify 3

▼ Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, should be filed within 7 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl J. Watkins Edith Mary Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 2: any injury or other t Lynne Hauff/ daughter 4036 Huckleberry Row Ellicott City MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crem. Serv. Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4-9-11 4 Donation 5 Other (Specify) Hanover, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 4112 Old Columbia Pike Ellicott City MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) OMONT OFF Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Pregnant at time of death Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRUNIC CBSTRUCTIVE PULMONARY DISCAR Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Itx ROPTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed PHEUMATOLD ARTHRITIS Yes 2 No 1 Yes 2 - No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, To the Hospital or within 24 hours aff To the Funeral Di Medical 29a. Certifier Quartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 MC Registrar's Signatur State Registrar

Amend Items 15 and 16 per DVR G918 8/15/11 dk

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1-02517	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	1298
Bryant Keith Brown, III	State of Maryland / Department of Health and Mental Hygiene	1600

1		1- For State Certificate o	f Health and Mental H <i>f Death</i>	10	
Physic		Decedent's Name (First, Middle, Last)		Reg. No. 2. Date of Death Month Day Year	3. Time of Death
lei ical Exam	ime	Dryane Refell Brown 111	4b. City, Town, or Location of Death	April 1, 2011	2206 hrs
		Queen Anne Medical Center	Queenstown	Queen Ann	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	-	. Birthplace (State or
Directo		216-83-8659 1 M 2 F 2 Yrs	Months Days Hours Min	12/1/2008	oreign Country) MD
ru h		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ion		10d. Inside City Limits
nd show	۱ ۾	MD Queen Anne's Centrevi	lle		1 X Yes 2 No
Maryla 28a-f	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What (Country?
h the l 23a or	Ö	304 Queen Anne's Circle	21617	USA	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? If Y	is Decedent of Hispanic Origin? (Sp es, specify Cuban, Mexican, Puerto	ecify Yes or No- 14. Race - Ar	merican Indian, Black, c.
fter de	Fu	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2 X No specify:	Specify: P	Black
sours a natura 'xamir	od be	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	it's Usual Occupation (Give kind of v	vork done 16b. Kind of Busine	
36 in 72 t	plet	College (1-4 or 5+)	ost of working life, DO NOT use retin	red)	
d with ygiene ygiene other t	Completed	n/a 17. Father's Name (First, Middle, Last)	18.Mother's Name	n/a (First, Middle, Maiden Surname)	n/a
215 be file ntal H rked o	Be	Bryant Keith Brown Jr.	Letin		lon
D 21 Should and Me is ma	٤	19a. Informant's Name/Relationship (Type, Print)	Address (Street and Number or R	Rural Route Number, City or Town, S	tate, Zip Code)
and 2 sealth a tem 27		Letina Deedon/Mother 304 20a. Method of Disposition 20b. Place of Dispos	Apt D4 Queen	ntreville, MD Anne's Cirxle Date 20c Location City	ZIDI/
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 3 Removal from State crematory or of	ield Cemetery	9/2011	
altin nit. Pa sartmes sortan ury or		The state of the s	ama and Address of Facility		rille,MD 216
Den Den		John H. & rince 185	5 High ST Ches	nnie Smith Fun stertown, MD 2	eral Home
Physician /Medical		23a. 2 rt I. Enter the sease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	ne mode of dying, such as cardiac or	respiratory arrest, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Seizure Disorder Due to (or as a consequence of):			Death
		Sequentially list conditions, b			
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
n #	Examine	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):			
Division of Vital Records, P.O. Box 68760, the Bospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and appetely filled in by the funeral director, page 2 should be detached for use as the burial - transit	alE	d. MUNPENDED AMENDED 23a, pt. II, 27, pe	www010 0 0 11		
50, te be e nysiciau	Wedical		r me,g918 8-2-11		
eath certificat attending ph	an/N	23b. Was decedent pregnant in the past 12 months?	al death 3 Ectopic pregnar	23d. Date of delivency Month	very Day Year
lox leath c	Physician/	4 Pregnant at time of death 5 Oth	er (Specify)		
O. But the d		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
signed	Completed by	Asthma		1 Yes 2 ✔ No 3 P	robably 4 Unknown
ords, P w requires t us been sign should be d	olete				autopsy findings available to completion of cause of
Rec i The lar	Ē			performed? death 1 ✓ Yes 2 No 1 ✓	?
ital Recient The certificate rector, page	Be	25. Was case referred to medical examiner? 1	26.Place of Death (Check or	nly one)	
Division of Vital Records, P.O. Box 687, tal or Attending Physician: The law requires that the death certifics as after death. 31 Director: After this certificate has been signed by the attending piled in by the funeral director, page 2 should be detached for use as the	P	1 763 2 140		Home 5 Residence 6 Ott	her:
ion of tending Pheath. tor: After the funeral	fion	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	28d. Describe how injury occurred	
ViSi or Atte fter de Directe	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	, factory, office building, etc.	28f. Location (Street and Number or	Rural Route Number, City
Divis spital or At tours after d neral Direct filled in by	Certification:	4 Homicide determined (Specify)		or Town, State)	
To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred one) 2 Wedical Examiner: On the basis of examination and/or investigation	ed at the time, date and place, and o	lue to the cause(s) and manner as st	tated.
To the within To the comple	Medi	and manner stated. 29b. Signature and title of certifier	29c. License number	the time, date and place, and due to 29d. Date signed (A	
		0.11/2	O.C.M.E.	April 2, 2011	nonui, Day, Teal)
	-	30. Name and address of person who completed cause of death (Item 23a)			
		Jack Titus MD. Deputy Chief Medical Examiner 111 Penr	Street, Baltimore, MD 212	201	
St	ate	31. Date filed (Monthi, Day, Year) 32. Registrar's Signature	el.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Veronika Day Month Bacemann 0312 YM Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 5 / 6 / 1 9 1 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F 99 Director 214-76-1364 <u>Hűngary</u> Usual Residence of Decedent show 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Lothian 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 20711 USA 5783 Pindell Road 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H Rudolf Weigoni Antonia Baumann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Main/Daughter and 2 s Health a 5783 Pindell Rd., Lothian, MD item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 ō <u>=</u> 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or Mem'l Gardens 4 Donation 5 Other (Specify) 4/13/11 Dunkirk, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Raymond-Wood F.H., PO Box 430, Dunkirk, MD 20754 00 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final -Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner NSTEMJ Sequentially list conditions, it dry, leading to incrediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed LTI Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f 1 Yes 2.2 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, COPD 1 Tes 2 No 3 Probably 4 Tunknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Division of Vital å 26. Place of Death (Check only one) Hospital Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 1 ☐ Yes 2 🗷 No မှ 1 Plnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 A Natural 5 Pending injury 2 Accident 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 10061783 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Pr. Frederick, Mp 20678 Ch Chana Hospital m.D. 100 31. Date filed (Month, Day, Year) 32. Registra s Signature APR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 4, 201 Pay William McKinley Brown 5:57 pm M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert County Nursing Center Prince Frederick Calvert Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea August 13, Funeral 9. Birthplace (State or Foreign 1 XM 2 □ F Days Hours Country Director Yrs. 215-26-0677 81 1929 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 705 Plum Point Road 20639 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Specify Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Grass Cutter** Self Employed other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Warren Brown Emma Chase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Vivian S. Brown - wife 705 Plum Point Road, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Seurial 2 Cremation 3 Removal from State Patuxent UMC Cemetery April 9, 2011 4 ☐ Donation 5 ☐ Other (Specify) Huntingtown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home, P.A. Glade 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscienatic Cardiovasiular dispass Medical resulting in death) Examiner Hypertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Diahes mellitus Type one uncontrolled 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Progressive End Stage 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an Degenerative Juint clisease 1 Yes 2 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify, ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Swrona. D. 50653 4-5-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURANA Deale churchton Road 31. Date filed (Month, Day, Year)

State Registrar

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

11-02830 Aaron Thomas Ball

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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	form	-	1.7	V

		Registrar		Cen	tificate of	Death			Re	eg. No.	
Physic Medical Exam		maron man	s Ball					2	Date of Dear Month April 13, 2	Day Yea	3. Time of Death 1649 hrs
		4a. Facility Name (if not institution 11671 Hopewell Road		per)	4	b. City, Town, Hagersto		of Death		4c. County o	
Funeral Director		5. Social Security Number 218-27-2367		Age (In yrs. Ia	st birthday) Yrs.		ear If Und		8. Date of Bir		9. Birthplace (State or Foreign Country) MT)
w any		Usual Residence of Decedent 10a. State 10b. County			Town or Location	on			03/23/	1700	10d. Inside City Limits
ne Maryland nr 28a-f show Ged at once.	ğ	PA Frank 10e. Street and Number		Me	ercersb						1 Yes 2 X No
th the Mar 23a nr 28a notified a	I Director	5232 Fort Loud				10f. Zip Code	236			0g. Citizen of Wh	at Country? USA
a, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mema Hygiene. tem 27 is marked inther than "outural", in ricens 23a in 23a-f shootrammatic event, the Medical Exeminer must be notified at once.	/ Funeral	11. Marital Status 1 XX Never Married 2 M 3 Widowed 4 Div	1 Yes		If Ye	Decedent of I	an, Mexicai	n, Puerto R		14. Race White Specify:	
ours al	d b	15. Decedent's Education (Spe	or Dates:	completed)	16a. Decedent	's Usual Occur	ation (Give	kind of wor	k done	16b. Kind of Bus	White siness/Industry
MD 21215-0036 12 should be filed within 72 h th and Memta Hygiene, 127 is marked inther than "o umatic event, the Medical E.	Completed by	Elementary/Secondary (0-12)	College (1-4 o	or 5+)	labore	est of working li	fe. DO NOT	Cuse retired	1)	animal	l food processo
21215-003 uld be filed withi Mental Hygiene marked nther ti		17. Father's Name (First, Middle,	,				18.Mothe	r's Name (F	irst, Middle, M	laiden Surname)	
2121 uld be fi Mental I marked	To Be	Matthew Ball 19a. Informant's Name/Relations			19h Mailing	Address /Sta			Willia		, State, Zip Code)
MD 2 shouth and 1 27 is numeric	-	Matthew Ball	fathe	r							PA 17236
re, l		20a. Method of Disposition 1 Burial 2 Cremation	2 Y Romaval from	20b. Pla	ace of Disposit	ion (Name of c	emetery.		Date		City or Town, State
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		4 Donation 5 Other Sp. 21. Signature of Funeral Service	pecify:	Cum Crem	ematory or other berland natorium	m.		04/15	/2011	Waynes	sboro, PA 17268
Depa Impe injur		1			22. M	iller-E	owers	ox Fu	neral	Home	1. DA 17225
Physician		23a. Part I. Enter the disease, or failure/List only one cause	complications that cause	ed the death. D	o not enter the	mode of dying	g, such as o	ardiac or re	espiratory arre	st, shock, or hear	t Approximate Interval
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injurir Due to (or as a cor								Between Onset and Death
!	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	nsequence of):	<u> </u>		-				
ed nsit	Examiner	cause. Enter Underlying Cause (Discass or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):							
760, icate be executed physician and the burial - transit	n/Medical	UNPENDED	d AMENDED								
8760, tificate be ex ng physician as the burial	II/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth		ncy 2 Feta	I death 3	Ectopic	c pregnancy	,	23d. Date of d	elivery Day Year
Box 68 ne death certi the attendin	Physicia	past 12 months? 1 Yes 2 No 9 Unk		at time of death	h 🗀	er (Specify)		, p, og., a., o,		l monur	Day Teal
P.O. es that the gned by the detache	<u>ā</u>	Part II. Other significant condition	ons contributing to dea	ath but not resu	ulting in the und	derlying cause	given in Pa	ırt I.			ute to the cause of death?
of Vital Records, P.C ag Physician: The law requires that ther this certificate has been signed In meral director, page 2 should be deta	Completed								24a. Was ar autopsy	24b. We	ere autopsy findings available or to completion of cause of
tal Reco	E								perform 1 Yes 2	ned? de	ath? Yes 2 No
ital Recician: The lician: The lician: The liciane licetor, page	Be	25. Was case referred to medical examiner?	Hospital:				e of Death				
Physical this	P	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of In		R/Outpatient 8b. Time of Inju		ury at Work			esidence 6	
Sion Attendia death. ctor: A	Certification:	1 Natural 5 Pendi	ng Apr 13, 201,	Year) 1	630 hrs	1	Yes 2	No Ca		w injury occurred rk equipment	
Divis	Sertification of the series of	4 Homicide determ	not be nined 28e. Place of I		e, farm, street,	factory, office	building, etc		or Town Sta	reet and Number ite) Il Road, Hagers	or Rural Route Number, City stown, MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ल	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of rainer: On the basis of exa	amination and/	death occurred for investigation	d at the time, d	ate and pla	ce, and due	to the cause(time, date ar	(s) and manner and place, and due	s stated. e to the cause(s)
	Ž	29b. Signature and title of certifier	A 00 a ;	\		29c. Licens	M.E.			29d. Date signed April 14, 201	(Month, Day, Year)
61	}	30. Name and address of person w	who completed cause of istant Medical Exa		*	reet Baltim	ore MD	21201			
	ite :			ar's Signature		Daitiff	OIG, WID	£ 120 l			
Regist	rar	APR 2 2 2011	www B.	parke	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH 9916 6/22/2011 JH State of Maryland Department of Health and Mental Hygiene | | For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Day 2011 Year Dorothy 14, Brune 10:35 A ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Country Meadows Frederick Frederick 232 S32 6296 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🏋 F Months Min. May 9, 1928 West Virginia 82 Yrs. Hours Director Usual Residence of Decedent 28a-f show Hygiene. other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 ☐ Yes XX No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6116 Brookhaven Drive 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 13 Elementary/Seconday (0-12) Education permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygier Important: If item 27 is marked other 1 any injury or other traumatic event, th Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ruford Ramsey Maggie Biller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>David Russell</u> (Son) 6430 Steeple Chase Lane, Manassas, VA 20111 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (*Name of* S**t**ceme**l-nomas**bry**l-phscopa**1 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 4/20/2011 Owings Mills, MD 21. Signature of Funeral Service Licensee Keeney & Basford P.A. Funeral Home Reme and Address of Facility P.A. Funeral Reme Bas Ford P.A. Funeral Reme B Church St., Frederick, MD 21701 Approximate Interval Between Onset and Death Ph sician/ Due to (or as a c / sequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed and trar Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the aid be detached f Yes 2 No g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 🏋 No 3 ☐ Probably 4 ☐ Unknown PYCASUNE 24b. Were autopsy findings available 24a. Was an has page 2 autopsy prior to completion of cause of death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 😿 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: At completed filled in by the Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D51643 4.15-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ND 31. Date filed (Month, Day, Year State PR 2 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Allan L. Blansfield 8:00 PM Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hartora If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 🗆 F 219-28-5737 75 Maryland Director 07/06/1935 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Cecil Rising Sun 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1788 Conowingo Road 21911 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ¥ Yes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed 3 X Widowed 4 Divorced Specify: White Viotnam 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Amtrak Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Frederick Blansfield Mildred J. Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 268 Preston Dr., VA 20186 Laura Pederson (Daughter) Warrenton, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ferris &Co. Inc. <u>04/12/2011| West Chester. PA</u> Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. Washington St., Havre de Grace, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ∜hysician/ Cardioun openty disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Palminny Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? bilatere 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 \(\sime\) No death? 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: မ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M. 1). 1065412 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) 21078 ame 25 levas 32. Registrar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 1, ^{Day} 2011 Concepcion Cromelin 8:45P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Manor Care Chevy Chase Chevy Chase 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2🗶 F Months Hours 10/31/1917 Director 93 Panama <u>579 62 5428</u> Usual Residence of Decedent show 10b. County 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f DC Washington 1 Kes 2 □ No 10e. Street and Number Hygiene. other than "natural", or items 23a or rent, the Medical Examiner must be 1 10f. Zip Code 10g. Citizen of What Country? Funeral 20015 3119 Rittenhouse St., NW Panama filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: Panamanian Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Diplomat Panama Government permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other i any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Aurelio Guardia Soledad Ponce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Shirey/Daughter 3119 Rittenhouse St., NW Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗆 Burial 2 🗡 Cremation 3 🔀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 04/06/2011 Falls Church, VA 21. Signature of Funeral Service License 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW Washington, DC 20016 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CEREYBRAL VASCULAR 15CHPMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Se quentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Day Year the 9 Unknown 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🗭 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 00057124 415/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao MD 10110 Molecular Dr., #206 Rockville, MD 20850

State

Registrar

31. Date filed (Month, Day, Year)

APR 06 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2

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Brian	Vincent	Cooper

DHMH 17 Rev 1/2001

		I- For State Registrar/Ampn-720b/Por/FHPQC/4_7_11cm Cer	tificate of Death	Reg. No.
Physici al Exami	an/	1. Decedent's Name (First, Middle,Last) Brian V. Cooper		2. Date of Death Month Day Year March 28, 2011 3. Time of Death 0359 hrs
		4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center	4b. City, Town, or Location of Dea Cheverly	Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la 17. Age (In yrs. la 20. Age (In yr	~	1
w any			Town or Location ashington, DC	10d. Inside City Limits
ith the Maryland 23s or 28s-f show	Director	10e. Street and Number 138 Ivanhoe St. SW #301	10f. Zip Code 20032	10g. Citizen of What Country? USA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked nither than "natural", or items 23a or 28a-f sho injury nr other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year	S. 13. Was Decedent of Hispanic Origin? (\(\) If Yes, specify Cuban, Mexican, Puer \(1 \) Yes 2 \(\) No specify:	
036 thin 72 hours af ne. r than "natural ledical Examin	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of during most of working life. Do NoT use re	f work done 16b. Kind of Business/Industry
21215-0036 uld be filed within 7 Mental Hygiene. marked niber than e event, the Medica	Be	17. Father's Name (First, Middle, Last) Brian Vincent Cooper	18.Mother's Nam Ther	ne (First, Middle, Maiden Surname) resa Robinson
MD 2' nd 2 should alth and Mo em 27 is ma	10	19a. Informant's Name/Relationship (Type, Print) Theresa Cooper/ Mother 20a. Method of Disposition 20b. P	19b. Mailing Address (Street and Number or 138 Ivanhoe St. SW lace of Disposition (Name of cemetery,	
Baltimore, oemit. Pages I ar Department of Hee impartant: If ite		1 X Burial 2 Cremation 3 Removal from State	rematory or other place) clar Hill Cemetery 4/	78 15/2011 Suitland, MD
hysician		23a. Part I. Enter the disease, or complications that claused the death.	9013 Annapolis Rd	idgen Funeral Service Lanham, MD 20706 or respiratory arrest, shock, or heart Approximate Interval
√Medical Examiner	d	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of)		Between Onset and Death
	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death). Last		
760, ficate be executed g physician and the burial - transit	dical Ey	d AMENDED	·	
Box 68760, e death certificate be the attending physic ed for use as the burned for use	Physician/Mec	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant in the past 12 months? 1 Pregnant at time of deal	2 Fetal death 3 Ectopic pregr	23d. Date of delivery Month Day Year
P.O.	þ	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ✔ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, ra or Attending Physician: The law require rs after death. The law certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	Completed			24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 V. 1 Ves 2 No 27. Manner of Death 28. Date of Injury Mar 28. 2011 Panding	26. Place of Death (Check ER/Outpatient 3 DOA Other Nursi 28b. Time of Injury 28c. Injury at Work?	ing Home 5 Residence 6 Other: 28d Describe how injury occurred
ivision I or Attendir after death. Director: A d in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At hor	0315 hrs 1 ☐ Yes 2 ✔ No	Subject shot 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	ल	4 Homicide determined (Specify) Local Street 19a. Certifier 1 Certifying Physician: To the best of my knowledge cone 2 Medical Examiner: On the basis of examination and	e, death occurred at the time, date and place, an	d due to the cause(s) and manner as stated.
To witi	Med	and manner stated. 9b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 28, 2011
22		O. Name and address of person who completed cause of death (Item 2 Zabiullah Ali, M.D. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 2	1201
Sta Regist		11. Date filed (Month, Bay, Year) APR 0 7 2011 32. Registrar's Signature		

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avid Cleveland		1- For State	ate of Maryla		artment of rtificate of		d Mental		Reg. No.	
Physicia Medical Examir	n/	Registrar 1. Decedent's Name (First, Midd)	e,Last)	••				Date of De Month	eath Day Yea	3. Time of Death 0801 hrs
Qicai Examii	ler	DAVID 4a. Facility Name (if not institution	n, give street and nu	CLEVE mber)		lb. City, Town, or I	Location of De	April 2, 2	2011 4c. County	
		Johns Hopkins Bayvie	w Medical Cen	ter		Baltimore			BA	LTIMORE
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 24	/lin	,	y 9. Birthplace (State or Foreign Washington Country)
Director		216-19-4593 Usual Residence of Decedent	1X M 2 F	35	Yrs.			JUNE	16 1975	Country
ku e	ŀ	10a. State 10b. County		10c. City	, Town or Locati	on			_	10d. Inside City Limits
<u>A</u>	5	MD BALTI	MORE		DUNDA	LK				1 Yes 2 No
Maryl.	Director	10e. Street and Number				10f. Zip Code		-	10g. Citizen of Wi	nat Country?
5-0036 led within 72 hours after death with the Maryland tygiene. other than "matural?, ar items 23a nr 28a-f shn the Medical Examiner must be notified at once.		2700 YORK WAY	I 42 Was Dea	adant Front in 11	C 142 Wa	21222	and Original	Constitution and	USA	Associate Indian Block
eath wi	Funeral		arried Armed Fo			Decedent of Hisp es, specify Cuban,				- American Indian, Black, e, etc.
after de	짓	3 Widowed 4 Div	1 Yes orced If Yes, Give Yea	2 <u>x</u> No	1 🗌	Yes 2 X No	specify:		Specify:	BLACK
hours :		15. Decedent's Education (Spec				's Usual Occupations of working life.			16b. Kind of Bu	siness/Industry
5-0036 led within 72 ho Hygiene. other than "nı the Medical Ex	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)		C TECH		•	GOVER	NMENT
5-0036 iled within 7 Hygiene.	틹	17. Father's Name (First, Middle,	_		II V A		8.Mother's Na	me (First, Middle	, Maiden Surname	
	å	SAVANNIS A PEO						A L. CLE		
and 2 should be fi lealth and Mental tem 27 is marked traumatic event,	₽[19a Informant's Name/Relationer ELINA L. CLEVE	and Peopl	es/Moth	er ^{19b. Mailing}	Address (Street	and Number of	or Rural Route No	umber, City or Tow	n, State, Zip Code)
ore, MD es I and 2 sho of Health and If item 27 is	ŀ	20a. Method of Disposition	LANDITIOITI			tion (Name of cen		Date		MARYLAND 21853 City or Town, State
Baltimore, vernit. Pages I a Department of He Important: If ite	ı	1 X Burial 2 Cremation		Jill State	crematory or oth	erplace) CEMETERY	/1	/11/2011	TAITDET	,MARYLAND
Baltimo permit. Page Department o Important: injury nr ntt	ŀ	Donation 5 Other Sp Signature of Funeral Service		1110						NERAL HOME, INC.
9 P P E		Quane Z	Calle	un						ARYLAND 20785
Physician		23a. Part I. Enter the disease, of failure. List only one cause	on each line.		. Do not enter th	e mode of dying, s	such as cardia	c or respiratory a	rrest, shock, or hea	Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a. Multiple Sta		Ð.					Death
		Sequentially list conditions.	b		.,.					
		if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence o	f):					
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tra no	dical	LINDENDED	d. AMENDED							
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5876 ortificat ling ph	돑	23b. Was decedent pregnant in the past 12 months?	e 1 Live b		2 Fet	al death 3	Ectopic preg	nancy	23d. Date of Month	Day Year
Box 6876C death certificate the attending phys of for use as the b	힐		4 Pregna	ant at time of de	eath 5 Oth	er (Specify)			+	
T the de ached t	<u>- 1</u>	Part II. Other significant conditi			esulting in the ur	nderlying cause gi	ven in Part I.	23e. Did	tobacco use contri	bute to the cause of death?
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Reco	Ē								ormed?	leath? Yes 2 No
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Physic Physic er this	<u> </u>	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 le		ER/Outpatient 28b. Time of In				Residence 6 how injury occurre	Other:
ion of tending Pheath.	Certification:	1 Natural 5 Pendi	A SMonth	Day,Year)	0010 hrs		s 2 V No	Subject sta		e u
Division tal or Attendit rs after death. al Director: A led in by the fu	를 클		tigation 28e. Place	of Injury - At ho	ome, farm, street	, factory, office bu	ilding, etc.			er or Rural Route Number, City
Div pital or ours afte teral Div		4 V Homicide determ	and the second second	Local Stree	et			or Town, 2906 Dunmu	State) irray Road , Balt	imore , MD
	9	29a. Certifier 1 CertifyIng Ph (Check only one) 2 Medical Exam	ysician: To the best							
To the company of the	ฆ⊢	29b. Signature and title of certifier	and manner st	ated.		29c. License				ed (Month, Day, Year)
		(1221	11		O.C.N			April 3, 201	
2		30. Name and address of person	who completed caus	e of death (Item	23a)				1	
ノン			uty Chief Medic			Street, Balti	more, MD 2	21201		
Sta	امه	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signatu	ire .			-		

DHMH 17 Rev 1/2001 OCME 2006 11-02521

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

min Leiby Coo		State of Maryland	•	ment of Hea ficate of Dea		aı Hyg				
Physici		Registrar 1. Decedent's Name (First, Middle,Last)			<u> </u>		Date of Death		3. Time of Death	
edical Exam	inei	John Leroy Coon				/	Month April 2, 201	Day Year	0039 hrs	
		 Facility Name (if not institution, give street and number 1101 Philadelphia Avenue Apt. 1 	r)		Town, or Location of an City	f Death		4c. County of Worceste		
Funeral			ge (In yrs. last t		der 1 Year If Under	24Hrs. 8	B. Date of Birth		Birthplace (State or	_
Director		224-11-5160 1XM 2[F	48	Yrs. Mont		Min		4, 1962	Foreigr Washingtor Country) DC	n,
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits								ts
	7	MD Worcester	000	ean City					1 Yes 2 No	ю
Maryland 28a-f show d at once.	Director	10e. Street and Number	1. 000		p Code		100	g. Citizen of Wha	at Country?	
with the Maryland ms 23a or 28a-f sho be notified at once		1101 Philadelphia Avenu		_1	21842			USA	A	
or items	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces	?	13. Was Deced If Yes, spec	ent of Hispanic Origi ify Cuban, Mexican, I	n? (Specit Puerto Ric	fy Yes or No- an, etc.)	14. Race - White,	- American Indian, Black, , etc.	
after de la	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	X No	1 Yes 2	No specify:			Specify:	White	
hours natur	ed t	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (during most of working life. DO			Occupation (Give ki	Give kind of work done 16b. Kind of NOT use retired)			siness/Industry	_
Baltimore, MD 21215-0036 permit. Pan 2 should be filed within 72 hours after death with the Maryland Department of Health and Mendal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ake injury or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 11	5+)		nter	,		Н	ouses	
15-0 iled w Hygie d othe		17. Father's Name (First, Middle, Last)				Name (Fir	st, Middle, Ma	aiden Surname)		_
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	Walter Bernard Coon Sr 19a. Informant's Name/Relationship (Type, Print)		19h Mailing Addres	Heles (Street and Numb	en Bi	nns	as City as Tayon	State Zin Code)	_
AD 2 shot th and 27 is umatic		John R. Coon/Son			1e Dr. Poi					
re, l s l and f Heath ff item er tra		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from S	20b. Płace	e of Disposition (Na natory or other place	me of cemetery,	Da	ate		City or Town, State	_
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		4 Donation 5 Other Specify:	_	ation Cen		4/6/1	.1	Chan	tilly, VA	
Balt permit Depart Impor injury		21. Signature of Funeral Service Licensee			Address of Facility	72 7	D11	A 7	- TA 2220	12
Physician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	I the death. Do	not enter the mode	of dying, such as car	MILSO diac or res	piratory arres	ALTIII t, shock, or hear	gton, VA 2220. Approximate Interval Between Onset and	al I
Examiner		Immediate Cause (Final disease a Contact Gunsh		f Head					Death	
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b								
	nine									_
ted Insit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								_
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED								
760, ficate be g physici the buri		IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the	me of pregnanc					23d. Date of d		
Box 6876(death certificate he attending phy d for use as the b	Physician/	past 12 months? 2 Fetal death 5 Ecropic pregn 4 Pregnant at time of death 5 Other (Specify)				regnancy		Month	Month Day Year	
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P.O.	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown			
ds, P equires t	Completed		-			-	24a. Was an		ere autopsy findings available	_
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	0	25. Was case referred to medical			26.Place of Death (C	heck only	1 Yes 2	No 1	Yes 2 No	_
Vita hysicia this co		examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie	nt 2 ER/C					esidence 6 🗸	Other Scene	
ion of Vital tending Physician: eath. or: After this certif the funeral director,	ion: T	27. Manner of Death 28a. Date of Inju 1 Natural 5 Pending FOUND Day,Y	ear) FO	UND:	28c. Injury at Work? 1 Yes 2 ✔ N	le	Describe how pject shot s	v injury occurred elf	t	
00 = 0 5 >	licat	2 Accident Investigation Apr 2, 2011 28e Place of In		33 hrs farm, street, factory		28f.			or Rural Route Number, City	
pital of cours af filled i	The state of the s							e) ia Avenue Apt	venue Apt. 1, Ocean City, MD	
	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
H % H S	¥	and manner stated. 29b. Signature and title of certifier		290	License number		2	9d. Date signed	(Month, Day, Year)	\dashv
q	-	30. Name and address of person who completed cause of d	enth (the 22 ·		O.C.M.E.		/	April 3, 2011		
1		Jack Titus MD. Deputy Chief Medical E.			et, Baltimore, Mi	D 21201				
Sta Registi		32. Registra	's Signature	1	<u>-,</u>					٦
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DHMH 17 Rev 1/2001 OCME 2006

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :35 pm CA 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FutureCare Chesapeake Anne Arundel Arnold 5. Social Security Numbe 260–22–4805 7. Age (In yrs. last birthday) 85 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Georgia **Funeral** 8. Date of Birth May 07, Year 925 1 □ M 2 🏖 F Months Min Director Yrs. Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified MD Anne Arundel Severna Park 28a-f 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe ms 23a must be Funeral 671 Faircastle Avenue 21146 USA "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death vlopatruent of Health and Mental Hygiene. Important: If item 27 is marked other turn "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc δ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Specify 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Benjamin Carl McCrary Martha Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Cline/ Son 671 Faircastle Avenue Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crown Hill Cemetery 20c. Location - City or Town, State April Date 09 1 🔀 Burial 2 □ Cremation 3 🔀 Removal from State 4 □ Donation 5 □ Other (Specify) Albany, GA 2011 Barrancodd & Stristy Severna Park Funeral Home P.A. 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition 120 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 Day Year 2 No Pregnant at time of death Unknown Yes sate has been signed by the a page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autops death? certificate 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: funeral director, 25. Was case referred to ___ical Be 26. Place of Death (Check only one) Other မ 1 Yes 2 1 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director. After this eath 27. Manner 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Injury at 28d. Describe how injury occurred atural 5 Pending 1 Yes 2 🗌 No filled in by the Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, de eath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu () PG State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Ann Circosta Month March 2011 7:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Anne Arundel Examiner 4b. City, Town, or Location of Death Atria Manresa Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 12, 1917 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 - M 2 -XF Illinois Director 350-07-3957 93 Usual Residence of Decedent 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 85 Manresa Road 21401 United States 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 2 No 72 hours after 1 Yes 2 No Specify. Year or Dates. WWII 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bridget (unk.) Patrick McNamara permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. anos. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan Circosta / Son 1550 Hampton Hill Circle, McLean, VA 22101 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Baltimore Crematory 4/4/2011 Baltimore, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part t. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ hknown Completed pluods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performe 2 🗆 No ☐ Yes 2 L 1 🗌 Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) To the within 2 29b. Signature and title of 29d. Date signed (Month, Day, Year, 20

Registrar
DHMH 17 Rev 7/2009

21215-0036

Maryland

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

son who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Year 0800AM No. RRIS APRI 2011 Medical **Examiner** 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death RIVER HOSPITAL CENT HESTERTOWN Funeral 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 😿 M 2 🗆 F Months Days 218-24-2762 82 192471928 **Director** Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 9201 Fairlee Road 21620 USA death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant; If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Road Maintenance State Highway Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Commodore Rachel Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Simons/Daughter Salt Lake DR Baltimore, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Pleasant U M 4/9/11 Chestertown, Church Cemeters (Facility Bennie Smith Funeral Home uneral Service Licensee Chestertown, MD 855 High Street 23a. Roft 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1810 (ich Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to lor as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atter detached for u in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed WO' D 1 ☐ Yes 2 ☐ No Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: မ 1 Tes 1) Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Time of Certificate: 28b. 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of p completed cause of death (Item 23a) (Type, Print) V6.V. Mortinez 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 6, 201 Pay Alnutt Chase, Sr. 6:50 р м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Nursing Home Prince George's Largo Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 6, 1915 9. Birthplace (State or Foreign Months Days Hours Min Director 213-14-8232 96 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Calvert 1 Yes 2 No Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 255 Kyler Road 20639 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married 2 X No Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Foreman Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henry Chase Elizabeth Gantt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Pamela Dyson - daughter 1890 Cool Springs Way, Huntingtown, MD 20639 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Patuxent UMC Cemetery: April 16, 2011 4 ☐ Donation 5 ☐ Other (Specify) Huntingtown, MD 21. Signature of Funeral Service Licensee Sewell Funeral Home, P.A. 22. Name and Address of Facility 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (o Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 No certificate 2 No 1 Yes 25. Was case referred to medical filled in by the funeral director. Be 26. Place of Death (Check only one) 1 Tyes 2 🔀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? Accident
Suicide Investigation Could not be 2 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registra State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 2011 JOSEPHINE V. CHESONIS 6:10 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GULL CREEK ASSISTED LIVING WORCESTER BERLIN If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Month, Day, 1 □ M 2 □XF Months Hours Min. VIRGINIA Director 213-10-9598 93 APRIL 191 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND WORCESTER BERLIN 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 MEADOW STREET 21811 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black. White, etc 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: WHITE If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည VANOKAS RICE MARY KUPCEUSKAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 BIRDNEST DRIVE, OCEAN PINES, MD 21811 NANCY H. HINES/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CREMATORY OF DELMARVA 4/5/11 DELMAR, DELAWARE 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Pall 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each limb. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition hysician/ erdiovarcula ews Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknowh Month Day Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 200 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 20140 ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date sigped (Month, Day, Year) 16001802 312 of person who completed cause of death (Item 23a) (Type, Print) exester. 1 cl 31. Date filed (Month, Day, Year) State 2011

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wanda Lee Cropper 4pril 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Pregional Medical Ce If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days Months Hours Min. 216-44-8761 09/24/1946 Mary I and Director Usual Residence of Decedent th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 ☐ Yes 2 🛛 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 607 Parker Road 21804 USA within 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Force Black, White, etc. δ 1 Never Married 2 K Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Day Care Provider Home Day Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Everett S. Baker Doris E. Littleton and 2 should be Health and Menta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Courtland H. Cropper/spouse 607 Parker Rd., Salisbury, MD 21804 njury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4/10/2011 Pittsville Cemetery Pittsville, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22 Name and Address of Facility Home Professional Association any 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending housing and the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) ned by the a detached f 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be d Records, Melintino 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available autopsy performed page 2 1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural within 24 hours after death.

To the Funeral Director: A completed filled in by the fi 1 Tyes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 EASTERN SHORE SALISBULY HD 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar	
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Certificate of Death

Yrs

10c. City, Town or Location

2. Date of Death

Day

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) MARY P. COULBY

3. Time of Death 20 f 1:50 PM

4a. Facility Name (If not institution, give street and number)

4b. City, Town, or Location of Death

4c. County of Death TALBOT

Funeral Director

show

death v

s filed within 72 hours after de la Hygiene.

other than "natural", or item

marked other

Physician

that the death certificate be executed

68760

Box

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Division of Vital Records.

Physician:

/Medical Examiner

> burialphysician the burial

attending p for use as t

signed by the best of the sign
certificate

After this

To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Physician/Medical

þ

Completed

Be

Certification: To

Medical

Baltimore, Maryland 21215-0036

218-20-7368 ar than "natural", or items 23a or 28a-f show Director Funeral 11 Marital Status <u>م</u> Completed permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once.

Be

THE GARDENS OF WILLIAM HILL MANOR 7. Age (In yrs. last birthday) 6. Sex 1 □ M 2 🕱 F

College (1-4or 5+)

EASTON Months

10f. Zip Code

21601

1 ☐ Yes 2 XNo Specify.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/12/1916

APRIL

9. Birthplace (State or Foreign MARYLAND

10d. Inside City Limits

Usual Residence of Decedent 10a. State

5. Social Security Number

TALBOT MD

EASTON

1 Yes 2 No 10g. Citizen of What Country? UNITED STATES

10e. Street and Number

545 CYNWOOD DRIVE

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give Year or Dates:

94

Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Black, White, etc.

WHITE

1 Never Married 2 Married 3 ₩ Widowed 4 Divorced

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Specify:

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

OWNER/OPERATOR

INTERIOR DESIGN

17. Father's Name (First, Middle, Last)

GUY H. PUTMAN

MARY D. FORD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

04/08/2011

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type. Print) N. STEFFENS SMITH/ SON IN-LAW

8635 NORTH BEND CIRCLE, EASTON, MD 21601

20a. Method of Disposition

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) SPRING HILL CEMETERY Date

20c. Location - City or Town, State EASTON, MD

Signature of Funeral Service Licensee

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami

Adult	Failun	e to	The	· ve
Due to (or as a co	onsequence of):			
E1-	+ .	1	/	AI

Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death

IF FEMALE

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

Year

24a. Was an autopsy performe 1 ☐ Yes 2 BNo 26. Place of Death (Check only one)

2 No 1 🗌 Yes

25. Was case referred to medical 1 Yes 2 No

27. Manner of Death

5 Pending investigation 6 Could not be

determined

28a. Date of Injury (Month, Day, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 □Yes 2 □ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Aut. Liv. N 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number RO77623 29d. Date signed (Month, Day, Year)

tt L-She

APR 0 6 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krysta 1 Thomas 31. Date filed (Month, Day, Year)

545 Cynwood Registrar's Signatur

Drive

State Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Angela Elizabeth Durette March 29, 2019 1900 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Takoma Park Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. 578-84-6310 (Month, Day, Year) 2 / 0 4 / 1 9 5 7 Director 53 Guvana Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 🗆 Yes 2 🔀 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 18308 Streamside Drive #302 20879 Guyana Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give à 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: "natural" 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'am jujury or other traumatic event, the Meone. Elementary/Seconday (0-12) College (1-4 or 5+) Human Resources Asst. Accounting Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ivan Burrowes Inez Seals 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20872Keisha Durette/Daughter 1001 Chillum Road #405 Hyattsville, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛣 Burial 2 🖵 Cremation 3 🗆 B Anoval from State cemetery, crematory or other place. Gate of Heaven 4/07/2011 4 Donation 5 Other (Specif Silver Spring, Md 21. Signature (f) neral Service Lio PATTATIP AD CERTIFIALDI FIUNERAL SERVICE, P.A. 3241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between metastatic Immediate Cause (Final Onset and Death Trysician, recta disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been simpled by the continue of the property that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? by pe mall Obstruction Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed Yes 2 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 40 1 Hipatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 22 Obineti D 68005 MARCH 30 2011 mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenus, Takoma Park, MD20912 Jenni ter Obrigal mo 31. Date filed (Month, Day, Year) State 06 2011 APR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Elizabeth Dowery 2205 M April 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 1 F Hours Country Maryland 452-66-5320 8971777 F926 84 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13513 Collingwood Terrace 20904 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 X Yes 2 No 1958If Yes, Give 1976 þ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Completed 3 Widowed 4 Divorced 1976 Black Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Medical Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Johnson Irene Armstrona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon K. Dowery - Spouse 13513 Collingwood Terrace, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) Lincoln Crematory 04/13/2011 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. Rudlan 232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Muocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Diabetes Sequentially list conditions if any leading to immediate Examine cause. Enter Underlying attending physician and for use as the burial-vansit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other မြ 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D67355 April 02. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Sherk. M.D. 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 06 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26^{ay} March 20 4 Dozier Patricia 12:08A.M Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death Rockville Montgomery National Lutheran Home Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min (Month, Day, Year) Director Yrs 229-32-8038 80 January 4 Massachusetts 1931 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Fairfax Annandale 1 🗆 Yes 2 🗓 No Virginia 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8312 Toll House Road 22003 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ıral", or iter I Examiner ı 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3XXWidowed 4 ☐ Divorced "natural" Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be filed 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed. Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) ည Schuyler S. Pyle Edna Jefferson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8312 Toll House Road, Annandale, Virginia 22003 Leonard H. Brown, Jr./Guardian Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fairfax Crematory 4/1/2011 |Fairfax, Virginia re of Foneral Service Lie 22. Name and Address of Facility Everly Community Funeral Care 6161 Leesburg Pike, Falls Church, Virginia 22044 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Ph_sician/ HΙ heimers End Stage disease or condition Medical resulting in death) Due to (or as a c 4 sequence of Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Dav 1 Yes 2 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA hours after death. uneral Director: After this 4 🔀 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 00050612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Veirs Drive Rockville Marylone 20850 9701 G. MAIIER MD

State Registrar 32: Registrar's Signature